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Case Study

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SPONTANEOUS UNILATERAL TWIN TUBAL ECTOPIC PREGNANCY: A CASE REPORT AND REVIEW OF THE LITERATURE

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ABSTRACT

We describe a rare case of spontaneous unilateral tubal ectopic pregnancy in a multiparous woman that was discovered postoperatively on pathological examination of the surgical specimen.

KEYWORDS: Unilateral twin tubal pregnancy, rare condition.

INTRODUCTION

In ectopic pregnancy, implantation occurs outside the uterine cavity after fertilization, whether in singleton or multigestational pregnancies.[1]

If not diagnosed and managed in a timely manner, an ectopic pregnancy can lead to serious complications.

The incidence of unilateral twin ectopic pregnancies is quite rare and is estimated to be 1 in 125,000 pregnancies and 1 in 200 ectopic pregnancies.[2,3,4]

Of the few reported cases of twin ectopic pregnancies, most have been managed surgically, however, very few cases have been managed conservatively.[5]

CASE PRESENTATION

This is a 35-year-old female patient with a pathologic history of treated peritoneal tuberculosis reported cured, regular menstrual cycles, G4P3 (3 live children delivered vaginally) G4 : Current uninduced pregnancy (patient had not received any infertility therapy); who presented to the obstetric emergency room for left lateralized pelvic pain; no notion of metrorrhagia; on amenorrhea of two months, her hemodynamic status was stable with BP: 12/08 mmHg, HR: 85 bpm.

On clinical examination, she had a soft abdomen with slight tenderness of the left iliac fossa, speculum examination showed a healthy cervix with no bleeding.

Pelvic ultrasound showed a left latero-uterine mass measuring 5 cm × 6 cm.

The laboratory results brought back by the patient were: Bhcg 12673IU/L, the patient's hemoglobin concentration was 8 g/dl.

A laparotomy was performed, exploration found an organized tubal mass of 6 cm long axis adherent to the uterine fundus; to the posterior aspect of the uterus and to the left ovary (**Photo 1**). Adhesiolysis was then performed followed by left adnexectomy. The right tube and ovary were unharmed.

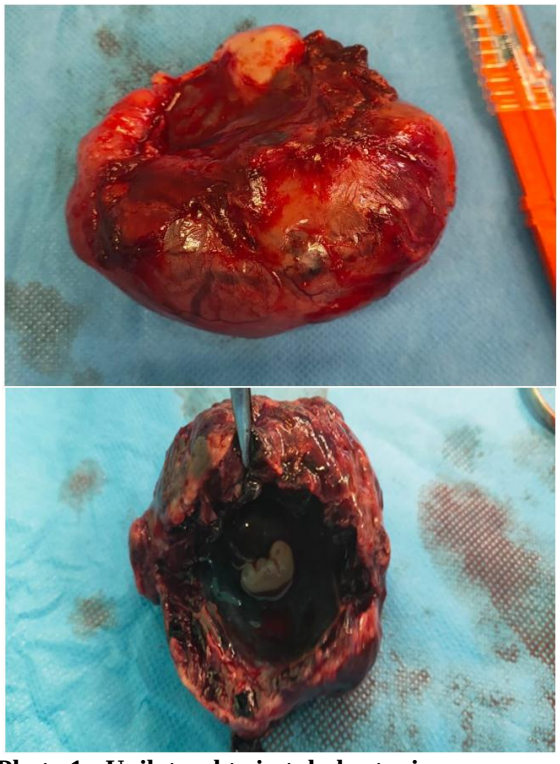

Photo 1: Unilateral twin tubal ectopic pregnancy.

The postoperative course was without complications.

The anatomo-pathological examination of the surgical specimen showed an ovular sac lined in the periphery by a blood clot closing villi with edematous axes surrounded by non-hyperplastic cyto and syncytiotrophpblastic cells containing 2 embryos; the first one of cylindrical shape measuring 1 cm in length and the second one (whitish spot) measuring 0.6 cm in length.

DISCUSSION

The first unruptured tubal twin pregnancy was diagnosed by Santos in 1986.[6] To date, 106 cases have been described in the literature. However, it should be noted that this condition is likely to be underreported because the diagnosis is mainly surgical or pathological.[1] Less than 10 of 106 cases were diagnosed preoperatively. Very few cases have been diagnosed with fetal heart activity in a live twin ectopic gestation.[7] Monochorionic and monoamniotic twin pregnancies are the most common (95%) among unilateral tubal twin pregnancies and will be unilateral. However, if it is dichorionic, diamniotic, it may be unilateral but may rarely present as bilateral ectopy.[8] The most common type of ectopic twin pregnancy is heterotopic (1/7000 pregnancies) in which ectopic and intrauterine pregnancies occur simultaneously.[6]

Its pathophysiological mechanism like other EPs could be secondary to reflux or non-progression of the fertilized oocyte.[9,10,11] It has also been postulated that the larger size of the twin cell mass itself causes the delay in transport.[12] In assisted reproduction, the transfer of several embryos could be a risk factor.[13]

Its clinical symptomatology is similar to that of other EPs. The classic triad of pelvic pain, metrorrhagia and secondary amenorrhea in a woman in a period of genital activity, as in our patient, has been described by almost all authors.[14,15] In blood tests, there have been no reports suggesting a difference in human chorionic gonadotropin values in twin ectopic pregnancies compared to singleton ectopic pregnancies, further complicating the diagnosis of twin ectopic pregnancy, making ultrasound the only test to differentiate twin ectopic pregnancy from singleton ectopic pregnancy.[1] It should also be noted that it is not always possible to demonstrate two different sacs on endovaginal ultrasound (such as the case we describe).

The evolution is rapid due to the overdistension of the tube, exposing it to early rupture.

Usually, the treatment of an ectopic pregnancy is based on its clinical presentation, gestational sac size, beta-human chorionic gonadotropin hormone levels, and complications and may require conservative, medical or surgical, or radical intervention. Because of the low incidence of spontaneous unilateral tubal twin pregnancies, no consensus has been reached regarding the best management option. For unilateral tubal twin pregnancies, the surgical approach appears to be the treatment of choice according to the literature, similar to single ectopic pregnancies.[1] The complication rate in twin ectopic pregnancies is reportedly higher than in single ectopic pregnancies, with the risk of rupture in 30 to 50% of cases.[16] Nevertheless, in carefully selected situations (for women wishing to preserve their fertility) and in the absence of contraindications, the use of methotrexate has proven to be an excellent alternative to surgical treatment with similar success rates.[17] In addition, some studies have agreed that medical treatment does not alter tubal patency or ovarian reserve (it may temporarily impair oocyte production).[18–19]

CONCLUSION

When diagnosing an ectopic pregnancy, even though it is rare, the possibility of a twin implant must be taken into account because of the higher risk of rupture.

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