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Case Report

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OVARIAN ECTOPIC PREGNANCY

M. M. Serroukh, M. Bouterfass, K. Moussaoui and Pr S. Bargach.

Department Of Gynaecology-Obstetrics, Cancerology and High Risk Pregnancies Unit, Maternity Souissi, Hospital Ibn Sina, Rabat.

***Corresponding Author: M. M. Serroukh**

Department Of Gynaecology-Obstetrics, Cancerology and High Risk Pregnancies Unit, Maternity Souissi, Hospital Ibn Sina, Rabat.

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ABSTRACT

The incidence of ovarian ectopic pregnancy is approximately 0.001% to 0.013% of normal pregnancies. A pregnancy with a Copper T device in situ is accompanied by an increased risk of ectopic pregnancy. Case Report: A 30-year-old woman with a copper intrauterine device complained of lower abdominal pain. She had a history of delayed menstruation. Her urine pregnancy was positive, vaginal touch showed tenderness; ßHCG=3800, ultrasound showed a right laterouterine mass with free fluid in the pouch of Douglas. Laparotomy showed hemoperitoneum and a ruptured right ovarian ectopic pregnancy. Wedge resection and reconstruction of the ovary were performed. Histopathologic examination confirmed the ovarian ectopic pregnancy. Conclusion: Recognizing an ovarian ectopic pregnancy is critically important and should be considered in the differential diagnosis of acute abdomen in women of childbearing age.

INTRODUCTION

Primary ovarian ectopic pregnancy is very rare condition, its incidence is about 0.001% to 0.013%.[1,2] Use of copper T device is suggested risk factor for ovarian ectopic pregnancy. Diagnosis is made using the Spiegelberg criteria,[3] which includes: gestational sac located in the region of the ovary, ectopic pregnancy is attached to the uterus by the ovarian ligament, ovarian tissue in the wall of the gestational sac is proved histologically, tube on the involved side is intact.

Prior to surgery, diagnosis of ovarian ectopic is seldom made, even transvaginal sonography is not very much useful for diagnosing this condition. We are reporting this case of ovarian ectopic pregnancy associated with IUCD (intra uterine copper T device) use, justifying that IUCD is one of the risk factor of ovarian ectopic pregnancy.

CASE REPORT

A 30-year-old female patient presented with a complaint of lower abdominal pain. She had one history of 2 weeks of delayed menstruation. The patient had a live child, the last birth being 2 years ago. She had an IUD inserted 10 months ago.

On examination, her vital signs were stable, pulse was 92/minute, blood pressure 100/60 mmHg.Intra-abdominal examination revealed tenderness.

Speculum examination revealed a healthy cervix and vagina, minimal blackish bleeding, and a T-shaped copper wire was visible. On vaginal touch a tenderness to movement of the uterus.

The urine pregnancy test was positive, and the ß-HCG level was 3800 IU/L (normal: <5 IU/L). Ultrasound showed a normal uterus, an obvious right adnexal mass, and free fluid in the pouch of Douglas.

The decision for laparotomy was made because pain increased and tachycardia developed. A hemoperitoneum of 450 ml was evident. The site of the ectopic pregnancy was identified on the right ovary, 3x2 cm, with bleeding on its surface. The uterus, bilateral fallopian tubes and left ovary were normal [Fig.1,2]. A wedge resection of the ovary was performed, removing the ectopic mass and reconstructing the ovary . The postoperative period was uneventful. Histopathological examination of the ectopic mass revealed an ovarian ectopic pregnancy.

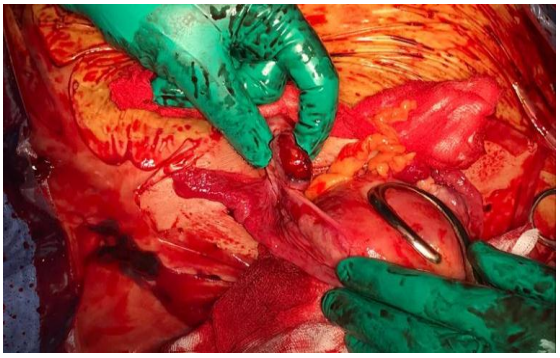

FIG. 1

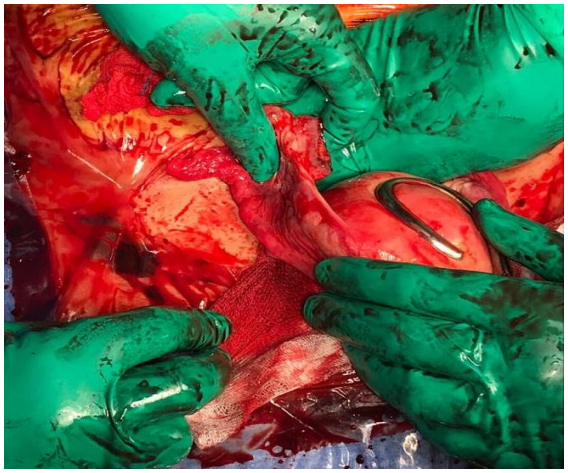

FIG. 2

DISCUSSION

Ovarian pregnancies account for approximately 1% to 3% of all ectopic pregnancies. Suggested risk factors include young age, endometriosis, pelvic inflammatory disease, intrauterine devices, ovulatory drugs, and assisted reproductive technologies.[3] In the present case report, IUCD was found to be a risk factor for ovarian ectopic pregnancy. IUCD prevents uterine implantation and tubal implantation by 99.5% and 95% respectively, with no effect on ovarian ectopic pregnancy.[3-6] Pre-surgical diagnosis of ectopic pregnancy is difficult, even ultrasound or trans-vaginal ultrasound can confuse it with a hemorrhagic corpus luteum or ovarian cyst.

Ovarian ectopic pregnancy can be treated conservatively with a single dose of methotrexate. However, the preferred mode of treatment is surgical, by laparotomy or laparoscopy.[7] In the past, ovarian pregnancy was treated by ipsilateral oophorectomy, but the trend has shifted to conservative surgery such as cystectomy or wedge resection performed by laparotomy or laparoscopy. Currently, laparoscopic surgery is the treatment of choice.[8] Future fertility is not affected after ovarian pregnancy.[7] In our patient, a laparotomy was performed because of the laterouterine mass with hemoperitoneum and the deterioration of the patient's vital functions.

CONCLUSION

Ovarian ectopic pregnancy is rare, but it should be considered in the differential diagnosis of acute abdomen in women of reproductive age.

Incidence of ovarian pregnancy is on rise due to increased incidence of infertility and use of assisted reproductive techniques.

Ultrasonography can detect ovarian gestations in unruptured cases but cannot easily differentiate ovarian from other tubal gestation in ruptured state. As most of the patients present with ruptured sac in collapsed state medical management is usually not feasible. Conservative surgical approach remains the management of choice.

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