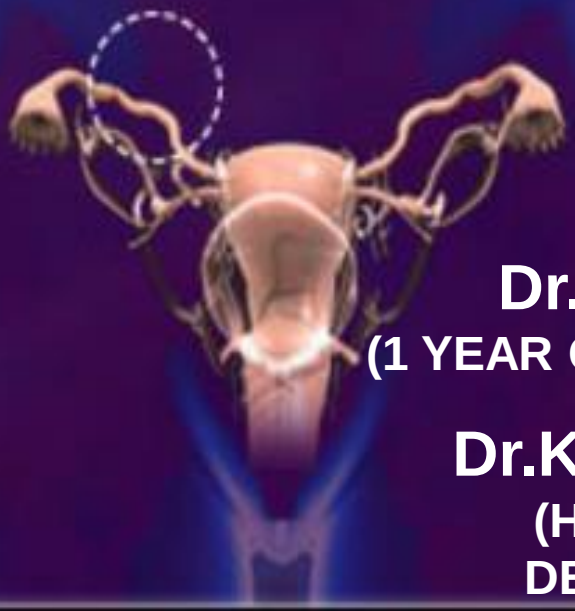
CLINICAL PRESENTATION OF A CASE PID~TURNED OUT TO BE ECTOPIC PREGNANCY



Dr.B.Saranya

(1 YEAR OBG PG IN SBMCH)

Dr.K.Saraswathi

(HOD OF OBG DEPARTMENT)

27 yrs. old lady, married 1½ yrs. presented to OP with

C/o lower abdominal pain and C/o spotting P/V from day 7 of the cycle

C/o fever for 10days.

MENSTRUAL CYCLE :

- Regular cycles.
- 3/28days cycle.
- Not associated with clots/pains.

MARITAL H/O:

- Married – 1½ yrs.
- Non consanguinous marriage.

PAST H/O:

- No h/o DM, HT, BA, Epilepsy, Thyroid.
- No h/o any previous surgeries.

PERSONAL H/O :

- Mixed diet.
- Bowel and bladder habits normal.

FAMILY H/O:

- Nil significant.

ON EXAMINATION:

- ✓ Patient anxious in pain
- ✓ febrile, hydration fair.
- ✓ Pallor +, No pedal edema.
- ✓ BP – 100/60 mmhg
- ✓ PR – 68/min
- ✓ CVS – s1s2 +.
- ✓ RS - NVBS+.

- ✓ P/A : Soft, bs+.
  Tenderness in right iliac fossa +.
- ✓ P/V – cx ↑ uterus retroverted
  ut normal size
  All fornices tender.

Diagnosis - 27yrs old lady
? ectopic pegnancy /?PID.

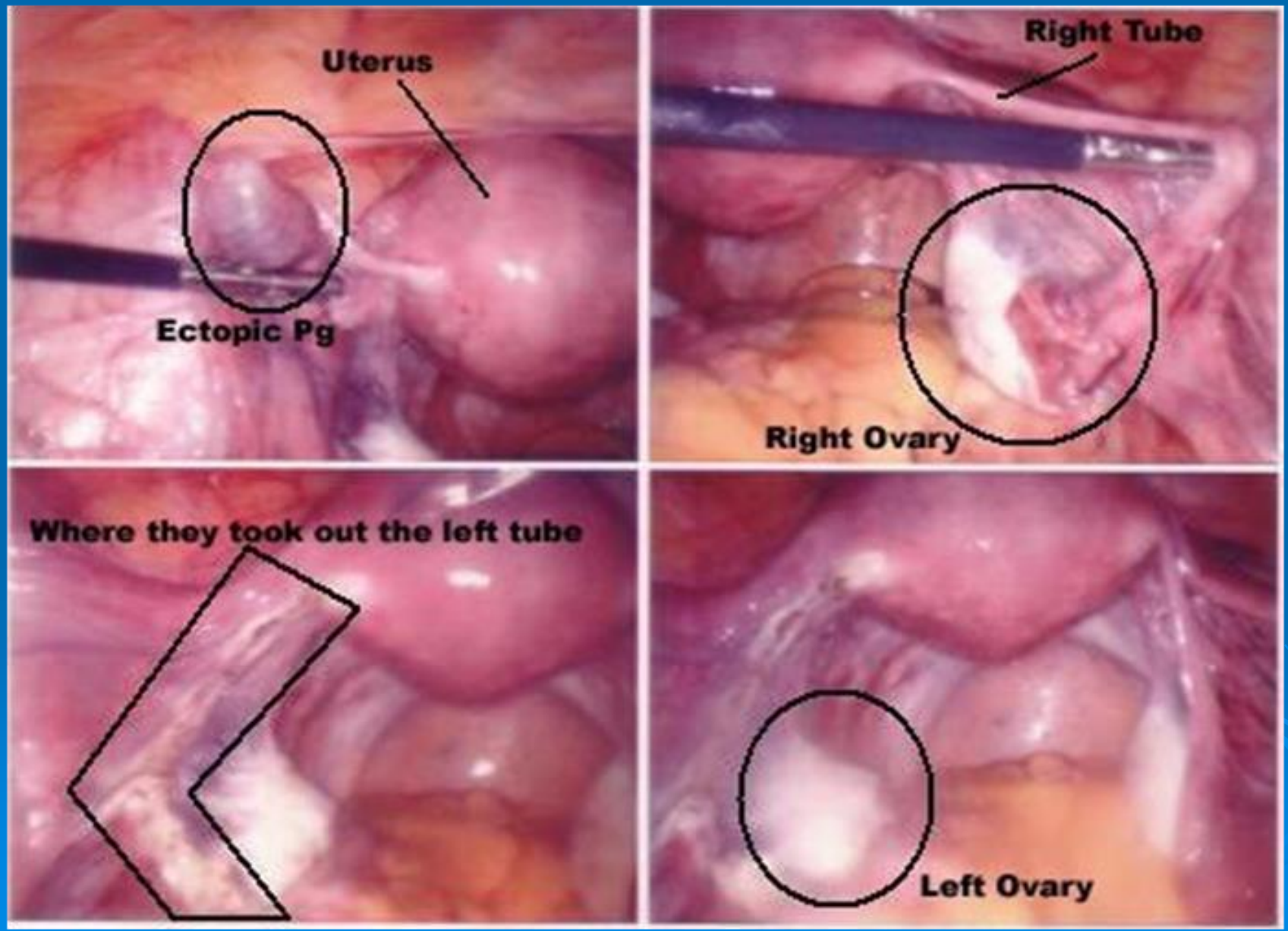
USG ABDOMEN:

- **A Heterogenous lesion 5.6×3cm in left adnexa close to left ovary.**
- **A ring lesion 2×2cm with thick hyperechoic rim and showing peripheral vascularity.**

Blood Investigation

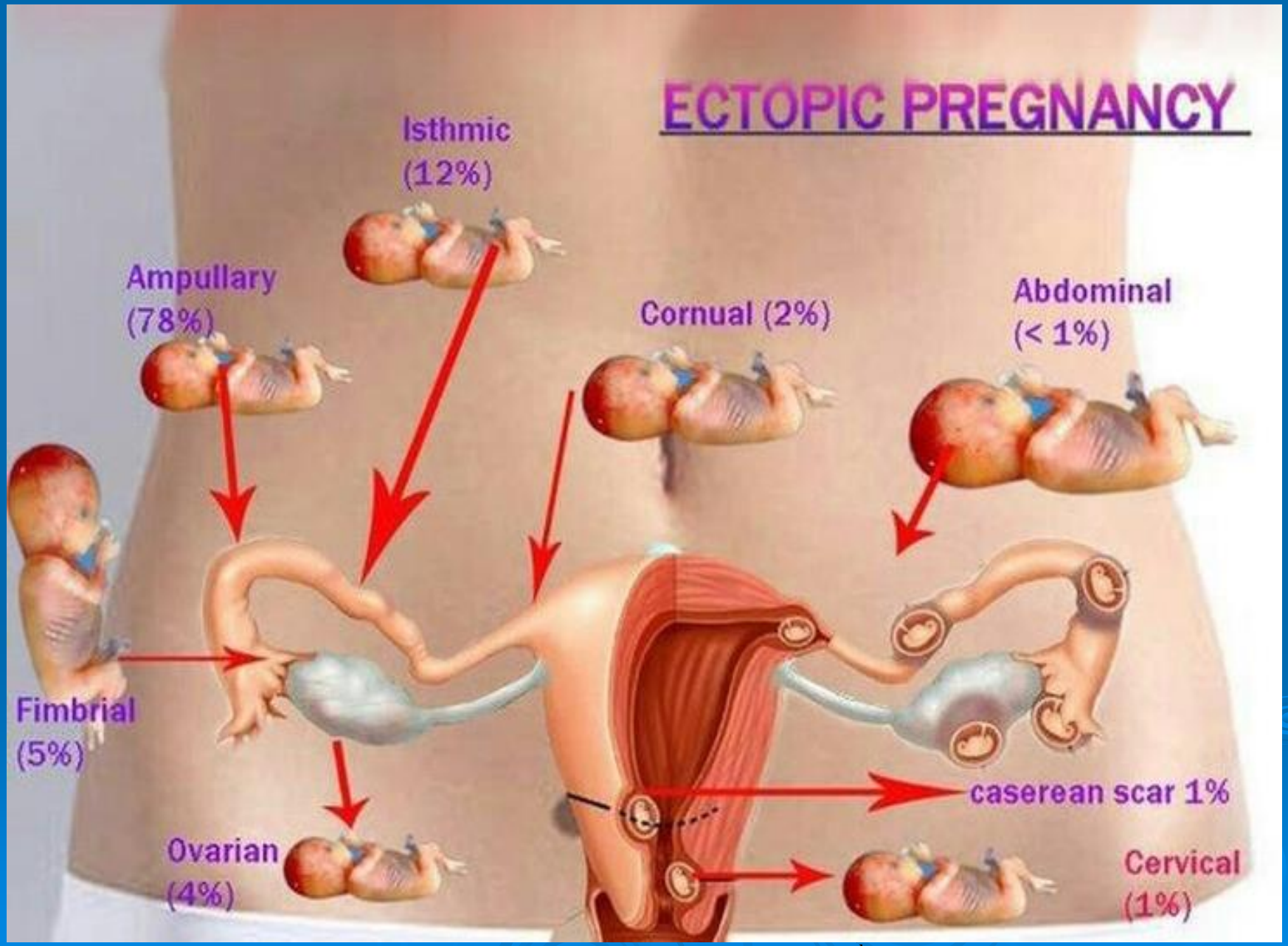
- β Hcg-672 miu/ml

2 *2 cm of G.sac (left isthumus)

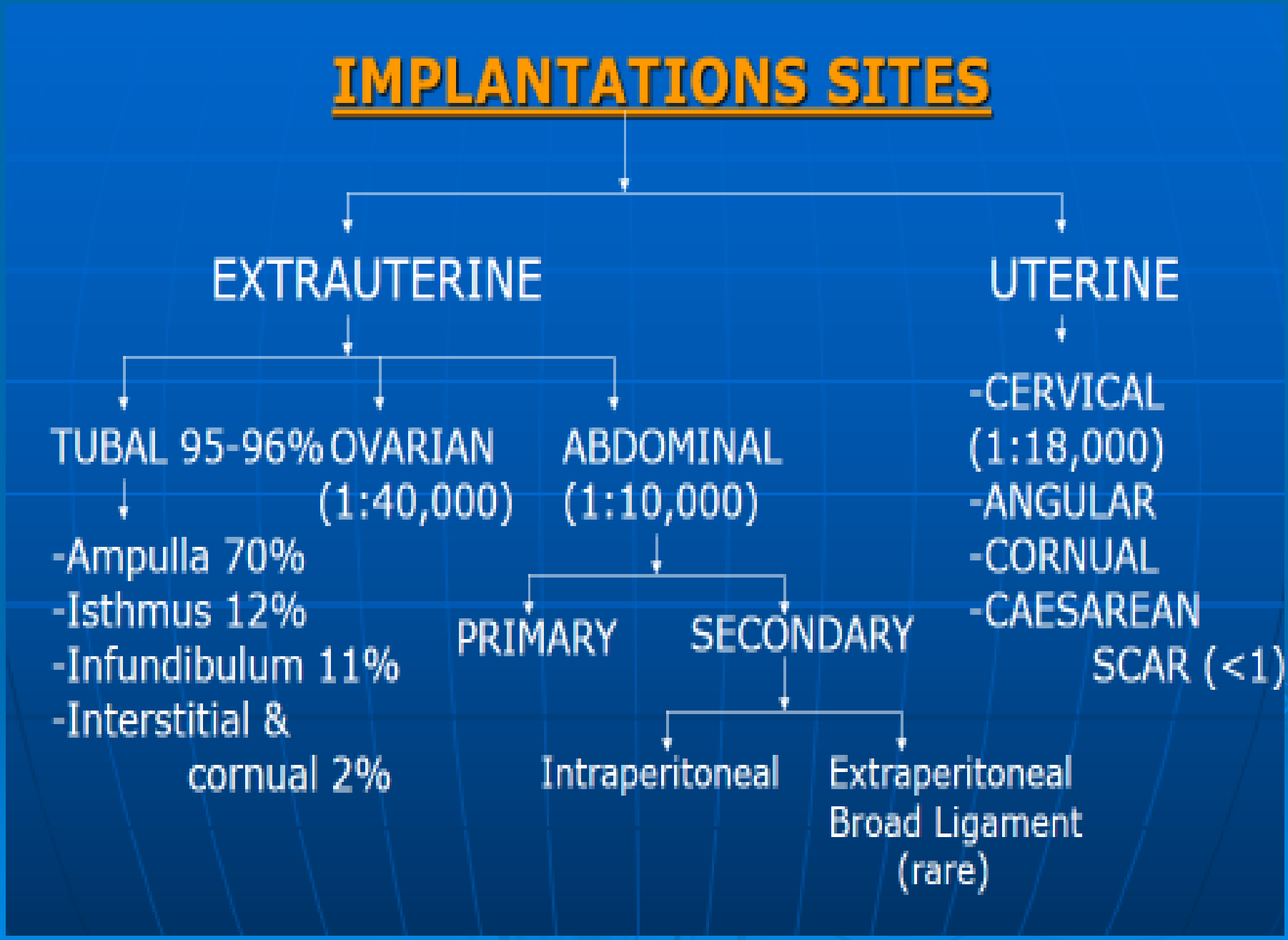


Ectopic Pregnancy

- An ectopic pregnancy is a complication of pregnancy in which the pregnancy implants outside the uterine cavity. Usually ectopic pregnancies are not only viable but are also very dangerous for the mother as it used to be followed by a massive internal bleeding.


ECTOPIC PREGNANCY
Isthmic
(12%)
Ampullary
(78%)
Cornual (2%)
Abdominal
(< 1%)
Fimbrial
(5%)
caserean scar 1%
Ovarian
(4%)
Cervical
(1%)

IMPLANTATIONS SITES



ETIOLOGY

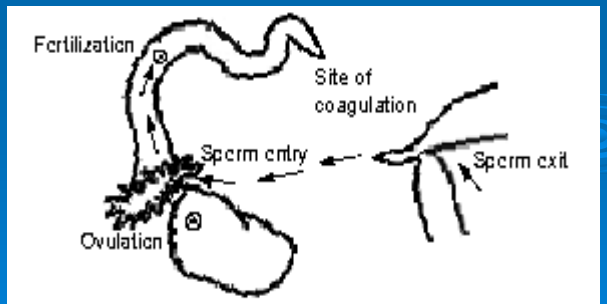
- Any factor that causes delayed transport of the fertilised ovum through the tube.
- Fallopian tube favours implantation in the tubal mucosa itself thus giving rise to a tubal ectopic pregnancy.
- These factors may be Congenital or Acquired.

CONGENITAL

- Tubal Hypoplasia
- Tortuosity
- Congenital diverticuli
- Accessory ostia
- Partial stenosis
- Elongation
- Intamural polyp
- Entrap the ovum on its way.

ACQUIRED CAUSES

- INCREASING AGE
- PID(6 TO 10 TIMES)
- TUBAL LIGATION
- CONTRACEPTION FAILURE
- PREVIOUS ECTOPIC PREGNANCY
- TUBAL RECONSTRUCTIVE SURGERY
- INFERTILITY



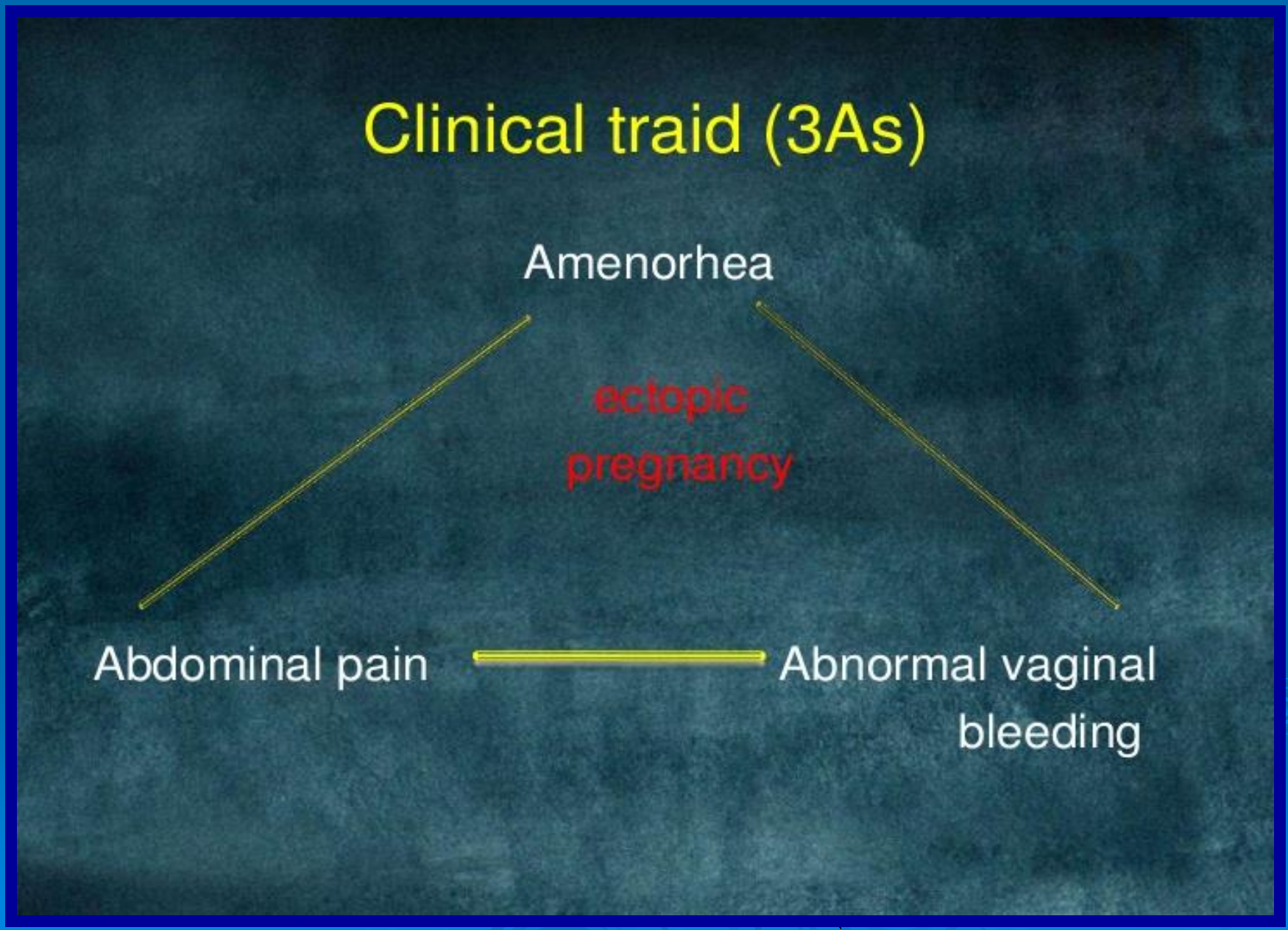
Mechanism of ectopic pregnancy after sterilization. Sperm exit the uterus through the site of coagulation and then enter the fimbrial end of the Fallopian tube to fertilize an ovulated egg.

- PREVIOUS ABORTIONS
- TUBAL ENDOMETRIOSIS.
- CIGARETTE SMOKING
- DES EXPOSURE
- FIBROIDS
- TRANS PERITONEAL MIGRATION OF OVUM.

ACUTE ECTOPIC PREGNANCY

CLASSICAL CLINICAL PRESENTATION

1. Short period of amenorrhea (btw 5 – 8 wks.)
2. +ve pregnancy test
3. Intermittent scanty Vaginal bleeding of dark blood (spotting)
4. Abdominal pain


Clinical traid (3As)
Amenorhea
ectopic pregnancy
Abdominal pain
Abnormal vaginal bleeding

CHRONIC ECTOPIC PREGNANCY

- Patient would have recovered from previous attack of acute pain.
- Pt may present with amenorrhoea, dull aching lower abdominal pain, vaginal bleeding, dysuria, frequency of micturation or retention of urine and rectal tenesmus.

INVESTIGATION

- BLOOD INVESTIGATION.
- β HCG.

SPECIAL INVESTIGATIONS

- ULTRASOUND.
- LAPAROSCOPY
- LAPAROTOMY
- DILATATION & CURETTAGE
- CULDOCENTESIS
- MAGNETIC RESONANCE
- IMAGING

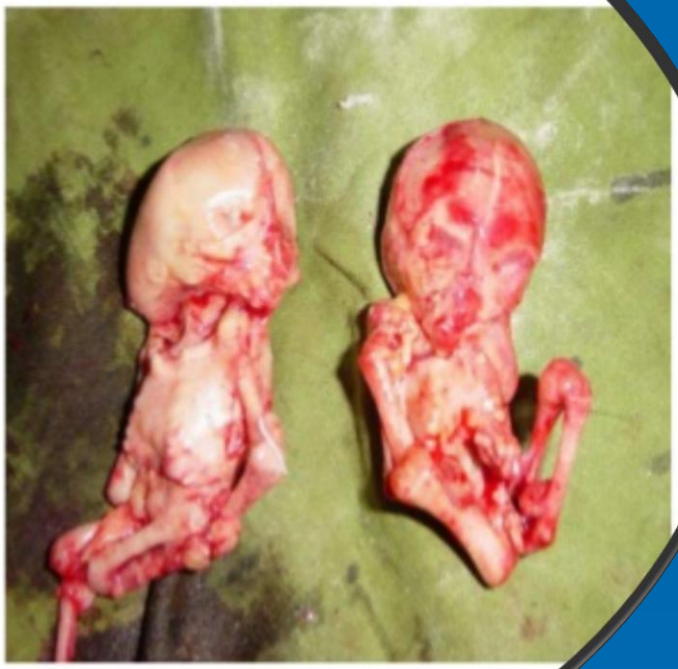
β HCG:

- URINE PREGNANCY TEST –ELISA IS SENSITIVE TO 10-50miu/ml. & ARE POSITIVE IN 95%OF ECTOPIC PREGNANCY.
- QUANTITATIVE BETA HCG VALUE THAT IN CONJUNCTION WITH TRANSVAGINAL ULTRASOUND CAN USUALLY MAKE THE DIAGNOSIS.
- WHEN HCG LEVEL < 2000 IU/L DOUBLING TIME HELP TO PREDICT VIABLE VS NONVIABLE PREGNANCY.

Complications

Massive bleeding, Anemia

- Pelvic abscess
- Peritonitis
- Sepsis
- DIC
- Pulmonary embolism
- Massive rectal bleeding or rectal passage of fetal bones
- MM 4% to 29%
- Fetal mortality is notoriously high, ranging from 75% to 95% of all cases



MANAGEMENT:

MEDICAL MANAGEMENT:

- The administration of methotrexate intramuscularly may be a suitable treatment for ectopic pregnancy in certain circumstances.
- Methotrexate is an antimetabolite which inhibits folate reductase .
- Administering a single 75mg IM injection of methotrexate is a suitable treatment for ectopic pregnancy in cases where beta hcg is<3000IU/ml.

THE REGIMEN INVOLVES ADMINISTRATION OF METHOTREXATE AS 1mg/kg on days 0,2,4,and 6 followed by 4 doses of leucovorin as 0.1mg/kg on days 1,3,5,7 because of higher incidence of adverse effect and increased need for motivation and compliance ,the multiple dosage has fallien out of favour in us.

SUITABLE CRITERIA:

- NORMAL RENAL AND LIVER FUNCTION
- SERUM HCG LESS THAN 3000IU/ML.
- MINIMAL OR MILD SYMPTOMS ONLY
- NO EVIDENCE OF HAEMOPERITONEUM
- ECTOPIC MASS LESS THAN 5CM DIAMETER.
- NO EVIDENCE OF FETAL ACTIVITY.

SURGERY:

- Laparotomy.
- Laparoscopy.

INDICATION:

- Pt not suitable for medical management.
- Medical therapy has failed.
- Pt has a heterotopic pregnancy with a viable intrauterine pregnancy.
- Pt is hemodynamically unstable and needs immediate treatment.

CONTRAINDICATED

- PT medically treatable.
- PT having other medical conditions that would make the risks associated surgery unacceptable,.

LAPAROSCOPY:

INDICATION:

MORE APPROPRIATE IN STABLE

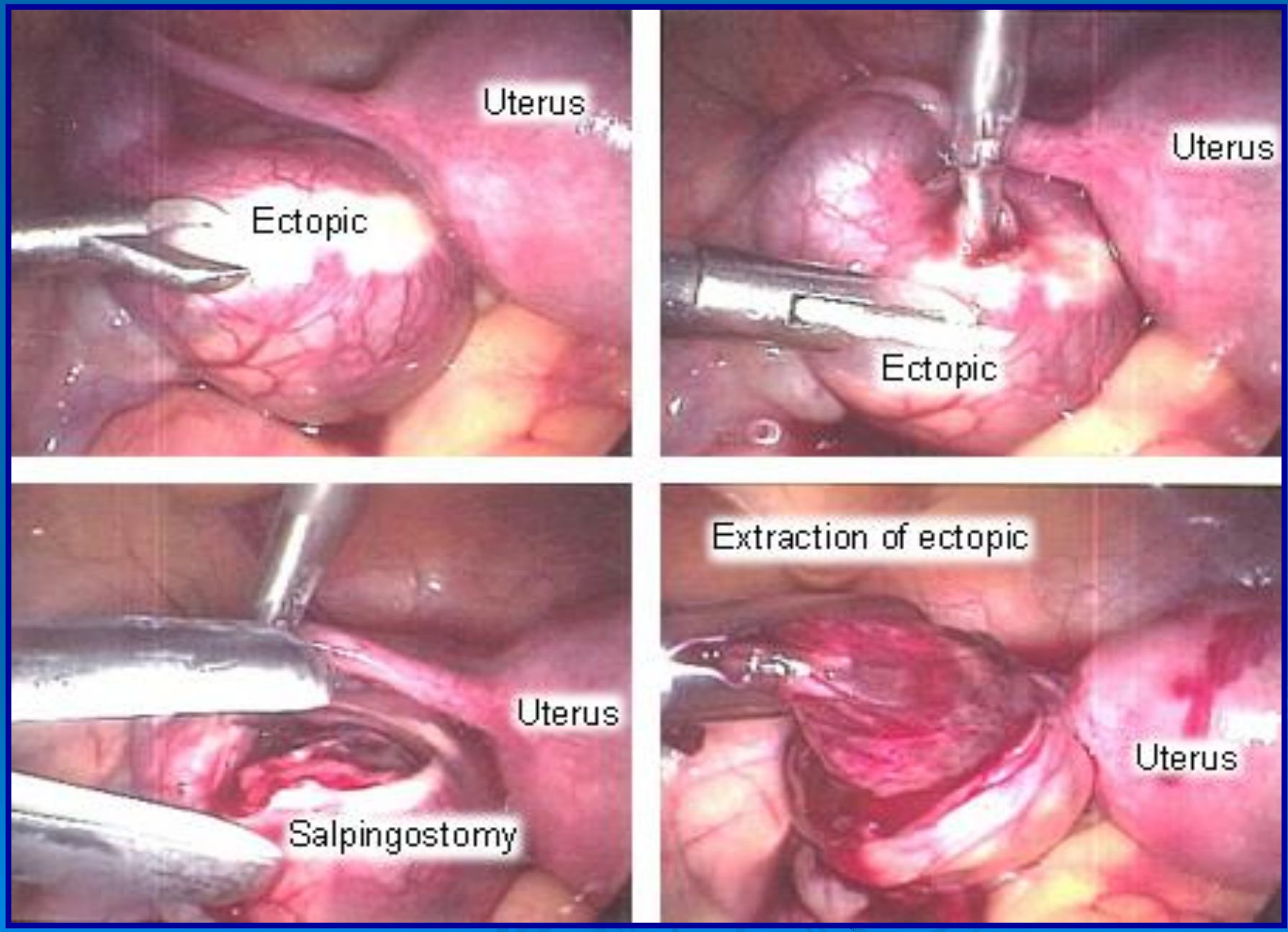
SITUATION.

SHORTER OPERATING TIME.

LESS BLOOD LOSS.

SHORTER STAY IN HOSPITAL

LESS NEED FOR ANALGESIA.


Uterus
Ectopic
Uterus
Ectopic
Uterus
Salpingostomy
Extraction of ectopic
Uterus

MILKING OR FIMBRIAL EXPRESSION:

- THIS IS IDEAL IN DISTAL AMPULLARY OR INFUNDIBULAR PREGNANCY.
- IT HAS GOT INCREASED RISK OF PERSISTENT ECTOPIC PREGNANCY.

Follow up after conservative surgery

- With weekly Serum β HCG titre till it is negative.
- If titre increases methotrexate can be given.

SUMMARY - KEY POINTS

- Incidence of ectopic pregnancy is rising while maternal mortality from it is falling.
- Ectopic pregnancy can be diagnosed early (before it ruptures) with recent advances in Immunoassay to detect S-hCG , high resolution USG, and dignostic Laparoscopy.
- There has been shift in the M/m from ablative surgery to conservative fertility preserving therapy
- Laparotomy should be done when in doubt
- The choice today is Laparoscopic treatment of unruptured ectopic pregnancy.
- Careful monitoring and proper counselling of patients is mandatory.

CASE OF TUBAL ECTOPIC PREGNANCY PRESENTED AS PID

A CASE OF 27YRS OLD LADY P3L3 PRESENTED WITH ABNORMAL MENTRUATION WITHOUT A PERIOD OF AMENORRHOEA WAS DIAGNOSED TO HAVE LEFT TUBAL ECTOPIC PREGNANCY AFTER P/V EXAMINATION AND ULTRASONOGRAPHY. MENSTRUAL CYCLES NORMAL.UPT –VE .BETA HCG 542IU/ML.PT WAS TAKEN UP LAPAROSCOPIC LEFT SALPINGECTOMY.

REFERENCES

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An ectopic pregnancy
can be more harmful to the
mother than a miscarriage

Thank you