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Case Reports

A CASE OF TUBAL ECTOPIC PREGNANCY

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ABSTRACT

A healthy 27 year old Para 3 presenting with abnormal menstruation without a period of amenorrhoea was diagnosed to have left tubal ectopic pregnancy after vaginal examination and abdominal ultrasonography. The case illustrates the need for careful history taking and the need for considering ectopic pregnancy in women in the reproductive age group, who have abnormal menstruation even if they are on contraception.
Keywords: Ectopic pregnancy

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INTRODUCTION

Ectopic pregnancy is a potentially fatal emergency condition if early diagnosis is missed.[1,2] The multitude of presentations to the primary care physician on first contact can be misleading in the absence of a high index of suspicion. The presentations vary widely from being asymptomatic to haemodynamically compromised.[2] This case illustrates a woman who has been on contraception without the classical symptoms of ruptured ectopic pregnancy.

CASE REPORT

A 27 year old Para 3 whose last child was delivered 2 years ago, presented to Pusat Perubatan Primer (Primary Care Centre) on the 4th of January 2006 with a complaint of heavy prolonged menstruation. Her last normal menstrual period was on the 7th of November 2005. Her menstrual cycle had always been regular with normal flow. The current menstrual flow started on the 7th of December and prolonged until the date of first consultation at the clinic. On further questioning, she admitted that she had initially taken treatment from another clinic to "increase" flow of her menstruation when she experienced scanty flow during the first three days of this cycle. Upon treatment her menstruation became heavy and prolonged and hence she sought a second opinion. There were no other complaints and the patient denied any pain or discomfort in the abdomen.

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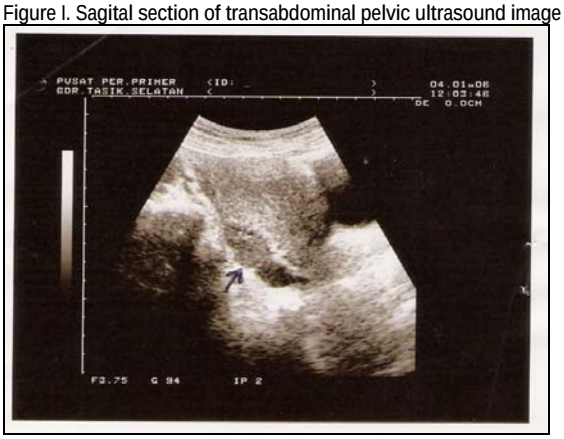
She has been married for nine years and had three spontaneous vaginal deliveries. She was on combined oral contraceptive pills started a year ago and claimed to be compliant with medication. There was no history of over-the-counter or prescribed medication taken during the last menstrual cycle. There were no significant past medical, surgical or gynaecological problems.

On examination she appeared comfortable and there were no signs of anaemia. Her blood pressure was 125/70 mmHg with a pulse rate of 85/min. Abdominal examination revealed mild tenderness over the lower abdomen. Vaginal examination excluded local causes of vaginal bleeding. On digital examination there was tenderness at the posterior fornix. Urine pregnancy test was positive. This was complemented by an empty uterine cavity with the presence fluid in the pouch of Douglas (arrow, Figure 1). Haemoglobin count was 12.3 x 10^3 g/L and total white cell count was 7.5 x 10^9g/L.

Figure I. Sagital section of transabdominal pelvic ultrasound image



The possibility of ectopic pregnancy was explained to her and she was transported immediately to the nearby hospital as she could collapse as a result of haemoperitoneum. The patient underwent diagnostic laparoscopy the same evening. There was haemoperitonium and a leaking left tubal pregnancy at the ampullary region. Both ovaries and the right tube were normal. Left salphingectomy and peritoneal lavage was done laparoscopically and patient was discharged well the following evening.

DISCUSSION

Ectopic pregnancy cases are relatively uncommon in primary care. Although it comprises only 2% of all pregnancies,[2] the incidence has been on the rise.[2,3] It is associated with high mortality if diagnosis and management is delayed. Early intervention carries significantly better prognosis.[4] Even surgery can be avoided if management starts before tubal rupture and cardiovascular compromise.[1] Hence, it cannot be over emphasised that early diagnosis is of paramount importance.

As illustrated in this case, diagnosis can be easily missed in the absence of classical symptoms of ectopic pregnancy compounded by incomplete patient assessment. The presentations of ectopic pregnancy vary from subtle abdominal pain to profound cardiovascular compromise. Common clinical presentations are as illustrated in Table1. Approximately 43-55% of ectopic pregnancies do not present with the classical triad of lower abdominal pain, period of amenorrhea and vaginal bleeding.[3,5] Early symptoms such as abdominal pain although the commonest, is not specific to ectopic pregancy[6]. About 9-30% of women may not have abdominal pain at presentation.[2,8] Differential diagnoses for abdominal pain in a young lady includes appendicitis, miscarriages, pelvic inflammatory disease and ovarian torsion.[5] Absence of a period of amenorrhoea in ectopic pregnancy is rather common and occurs in about 25% of cases.[4,9] A detailed menstrual history is important and any sudden change of menstrual pattern should alert the physician to think of the possibility of tubal ectopic pregnancy even in the absence of a clear period of amenorrhoea in women in the reproductive age group.

Table 1: Common clinical presentations of ectopic pregnancy[5,6,8,9]

Signs and symptoms	Number (%)
Abdominal pain	90-97
Abdominal tenderness	87-91
Nausea or vomiting	80
Vaginal bleeding	79-83
Amenorrhea	75
Dizziness	55-60
Adnexal tenderness	54-57
Shoulder or neck or pleuritic pain	50
Cardiovascular compromise	50

This was a challenging case as the presentation was not the typical sequence of events. Absence of typical symptoms tends to mislead physicians from the possibility of an ectopic pregnancy. Hence, a high index of suspicion for this condition at the primary care level is emphasised. It also highlights the fact that the first episode of abnormal vaginal bleeding in a sexually active woman may be a clue to the underlying diagnosis of ectopic pregnancy and should not be dismissed as dysfunctional uterine bleeding.

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