Ectopic Pregnancy Reimplanted to Douglas Pouch After Tubal Abortion: A Case Report

İbrahim ALANBAY, S. Temel CEYHAN, Kazım GEZGİNÇ, K.Emre KARAŞAHİN, Uğur KESKİN Ali ERGÜN, İskender BAŞER

Ankara, Turkey

A 26 year old Gravida1 Para 0 patient has admitted to our outpatient clinic with the complaints of missed menstrual period, inguinal pain and vaginal spotting for two days. The patient who had an endometrial thickness of 15 mm in her transvaginal ultrasound had no other pathological findings except for a minimal tenderness in deep abdominal palpation. Her β-hCG was reported as 556 IU/ml, therefore she was scheduled for serial β-hCG follow up.

Since the follow up revealed first falling and then increasing levels of β-hCG, the possibility of a tubal abortion followed by reimplantation came into discussion. A diagnostic laparoscopy was planned. During laparoscopy, an ectopic pregnancy mass of 2–3 cm was seen to be implanted on the pouch of Douglas. Minimal bleeding was observed from the fimbrial end of the left tuba uterina. Ectopic pregnancy focus was extirpated by a laparoscopic forceps. Pathological examination supported the initial diagnosis of ectopic pregnancy. The patient was followed until the postoperative 6 th week, when the β-hCG level was reported to be <5 IU/ml.

We wanted to present this case of ectopic pregnancy implanted to Douglas pouch after the tubal abortion, which we haven't encountered in the literature previously.

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Key Words: Ectopic pregnancy, Tubal abortion, Reimplantation

Introduction

Ectopic pregnancies account for approximately the 2% of all pregnancies, and are the 4th common cause of maternal mortality.[1,2] Clinical presentation of ectopic pregnancy is quite variable. There is a wide spectrum of presentations from mild vaginal bleeding to hemoperitoneum and shock. The presence of a tubal rupture increases the magnitude of the symptoms and findings. A persistent ectopic pregnancy is defined by the increasing or subnormally decreasing levels of β-hCG following the treatment. While different numbers are reported in the literature, usually a persistance of 5-8% is reported after salphingostomy.[3,4] The viabilitiy of the trophoblastic tissue indicates to the tubal implantation and infiltration. The gradual increase β-hCG in serial measurements is the indicator of the viability of the trophoblastic tissue. Along with that, transvaginal ultrasonographic examination helps us to localize the ectopic pregnancy and the presence of a tubal rupture.[5] While the trophoblastic persistance is usually at the tubal region, we would like to present a unique case of ectopic pregnancy initially implanted on the tubal region, and which implanted into the pouch of Douglas following a tubal abortion. We have not encountered such a case in the literature before.

Department of Obstetrics and Gynecology Gülhane Military Medical Academy Etlik/Ankara, Turkey

Address of Correspondence: *Kazım Gezginç*
Department of Obstetrics & Gynecology
Gülhane Military Medical Academy
Etlik/Ankara, Turkey
kazimgezginc@hotmail.com

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Case Report

26 year old Gravida 1 Para 0 patient was admitted to our outpatient clinic with vaginal bleeding for two days, a history of delayed menstruation and inguinal pain. She had 6 weeks of pregnancy when the first day of her last menstrual period was concerned. Pelvic examination revealed minimal tenderness. She did not give a history of previous pelvic or tubal surgery. Transvaginal ultrasound had no abnormal findings except for a 15 mm thick endometrial echo. There was no sign of intraperitoneal bleeding when the douglas pouchs scanned by TV ultrasound. While she had minimal tenderness in deep abdominal palpation, she had no rebound tenderness. β-hCG assay was reported as 556 IU/ml. She was hospitalized for follow up. β-hCG after 48 hours was reported as 257 IU/ml. She had a dilatation and curettage procedure, and was scheduled for follow up. 3rd day β-hCG was 180 IU/ml, but at the 9 th day after the intervention it was reported as 290, and at the 15th day it was 617 IU/ml. Patients complaints started to increase along with the progressive escalation of β-hCG levels, therefore a diagnostic laparoscopy was planned. At laparoscopy, a 2-3 cm mass of ectopic pregnancy material was

observed in Douglas pouch (Figure 1). Minimal spotting style bleeding was observed from the left tubal fimbria. Both ovaries and the right tuba uterina was observed to be normal. The ectopic pregnancy material was extirpated by laparoscopic forceps. Hemostasis was achieved. Pathological examination was reported as ectopic pregnancy. At the post procedural 6th week, β-hCG was seen to be decreased to less than 5 IU/mL.

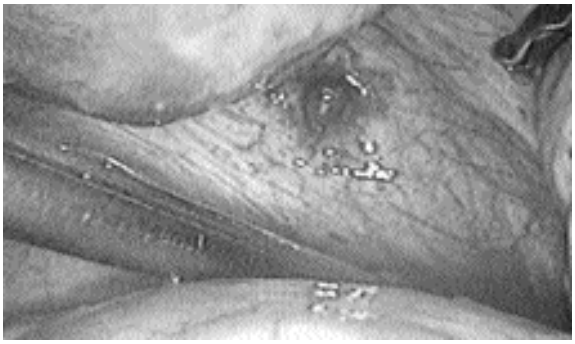

Figure 1: Mass of ectopic pregnancy was in Douglas pouch

Discussion

Ectopic pregnancy is among the most important reasons of maternal morbidity and mortality. By the increased use of transvaginal ultrasonography in the last two decades and with the availability of serial β-hCG measurements, maternal mortality and morbidity decreased. The gradual decrease of β-hCG following the ectopic pregnancy treatment is the sign of decreasing viability of trophoblastic tisssue. Secondary trophoblastic implantation following the treatment is a rare event. This could be seen in different peritoneal and visceral regions.[6,7] Reimplantation reveals itself as persisting β-hCG levels after the treatment. In the literature, reimplantation has been reported generally due to the persistance of the trophoblastic tissue, spread intraperitoneally especially following laparoscopic salpingostomy.[8] Our case differs from those in the literature in that it is an implantation following a spontaneous tubal abortion. Present literature mostly mentions about cases following salpingostomy, and to a lesser extent cases following salphinjectomy. No cases of reimplantation following expectant management has been reported. Complications generally seemed to follow laparoscopic interventions. Since the exact localization of reimplantation regions following post methotrexate applications and expectant management cases are not known, a real incidence can not be reported. We suggest to follow up the conservatively managed cases and medically treated patients more closely. Patients should be followed up until the β-hCG titers are negative. The possibility of reimplantation should be kept in mind as long as β-hCG is persistent. If the levels of β-hCG increase (or not decrease sufficiently), methotrexate application or a laparoscopy option should be evaluated.

Tubal Abortus Sonrası Douglasa İmplantasyon Gösteren Ektopik Gebelik Odağı

İbrahim ALANBAY, S.Temel CEYHAN, Kazım GEZGİNÇ
K.Emre KARAŞAHİN, Uğur KESKİN, Ali ERGÜN
İskender BAŞER

Ankara, Türkiye

26 yaşında gravida 1, parite 0 olan hasta kliniğimize, iki gündür mevcut olan vajinal kanama, adet rotarı ve kasık ağrısı şikayeti ile başvurdu. Transvajinal ultrasonografide endometrial kalınlığın 15mm olması dışında herhangi bir patolojik bulgusu olmayan, abdominal muayenede ise derin palpasyonda minimal hassasiyeti olan hastada β-hCG değeri 556 IU/ml olarak saptanması üzerine hasta seri β-hCG takiplerine alındı. Takipler esnasında β-hCG değerinin öncelikle düşüp sonrasında artması hastada muhtemel bir ektopik odağın abort sonrası reimplantasyonu olabileceği kanaatını uyandırınca hastaya diagnostik laparaskopi yapıldı. Hastanın laparoskopik değerlendirilmesinde douglasa yerleşmiş yaklaşık 2-3 cm ebadında ektopik gebelik mataryeli izlenmiştir. Sol tubal fimrial uçtan minimal lekelenme tarzında kanamanın olduğu gözlendi. Ektopik gebelik mataryeli laparaskopik olarak forseps yardımı ile ekstirpe edildi. Patolojik inceleme sonucu gebelik materyali olarak rapor edilen hasta postoperatif 6'ncı haftada β-hCG değeri<5 IU/ml gerileyinceye kadar takip edildi. Biz bu vaka taktiminde tubal abortus sonrası douglasa reimplantasyon gösteren ve literatürde daha önce rastlamadığımız bu olguyu sunmak istedik.

Anahtar Kelimeler: Ektopik gebelik, Tubal abortus, Reimplantasyon.

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