



Interstitial pregnancy

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Introduction

Interstitial pregnancy constitutes about 2% of total ectopic pregnancies¹. It used to be typically diagnosed at 12 weeks gestation or later². The advanced gestation and proximity to large uterine vessels carries a high risk of mortality. The patient usually requires hysterectomy and multiple blood transfusions. This case shows the advantage of early diagnosis and prompt management.

Case report

A 32 year old, G2 P1, presented with 1 month and 8 days amenorrhea with a positive urine test for pregnancy. She had already been advised to report early whenever she missed her period because she was at high risk of having an ectopic pregnancy due to past history of (a) secondary infertility (b) pelvic tuberculosis, and (c) right tubal pregnancy needing salpingectomy.

The patient did not complain of any abdominal pain or vaginal bleeding. General examination did not show any abnormality. A bimanual examination revealed normal sized uterus and absence of any mass or tenderness in the pelvis. Routine blood tests were within normal range. Ultrasound showed a normal sized uterus without any intrauterine gestational sac, pelvic mass or free fluid in the pouch of Douglas. However, the left ovary was slightly enlarged. The ultrasound report was no intra- or extrauterine pregnancy. As beta hCG level was 2800 IU, one had to find its source. Hence diagnostic laparoscopy was done. It showed an interstitial pregnancy

on the left side, about 5 cm in size. Probably this resembled an enlarged ovary on ultrasound. The couple was counseled regarding medical management by inj. methotrexate^{3,4}. They were not prepared to face the slight unpredictability associated with medical management⁵ and opted for surgical treatment. Consent was taken for hysterectomy if needed and blood was sent for cross matching. At laparotomy, the left interstitial area was very vascular with engorged vessels running all over its surface. An incision was taken over the least vascular part i.e. the superior surface. The products of conception were separated by blunt dissection and removed. Surprisingly, hemostasis could be easily achieved by bipolar coagulation. A single mattress suture was taken to approximate the edges of the incision. Tubectomy was advised in view of high chances of ectopic pregnancy in future. But this was refused. Postoperative recovery was good. No blood transfusion was required. The patient went home after 2 days. As is mandatory for all conservative procedures, β hCG level was done 10 days later. It was normal.

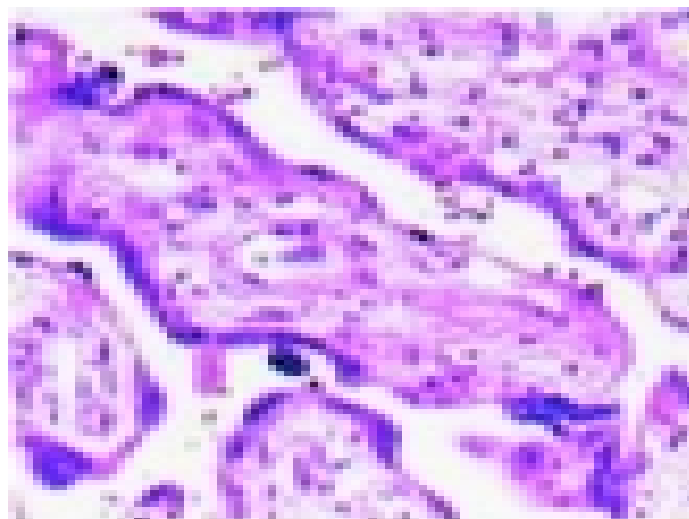


Figure 1. Chorionic villi

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Histopathology study of the products removed at laparotomy showed chorionic villi (Figure 1).

Discussion

Although this is an uncommon condition, a high index of suspicion of ectopic pregnancy in a high-risk case can help in early diagnosis of this life threatening condition, much before the patient becomes symptomatic. In this case, even though the ultrasound findings were not helpful, β hCG levels indicated the need to do laparoscopy, which has been the gold standard for diagnosis and management of ectopic pregnancy. As this patient was diagnosed very early, blood transfusion, emergency management and hysterectomy could be avoided. Early diagnosis also avoided cornual resection that in turn, reduces chances of uterine rupture in future pregnancy – a situation not applicable in the present case where the right tube was removed earlier. Also, potential rupture of interstitial pregnancy at 12 to 14 weeks of pregnancy, which carries a high risk of mortality, was avoided. β hCG and ultrasound are

complimentary to each other, and help in early diagnosis and conservative management of ectopic pregnancy and minimize morbidity and mortality.

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