



Isthmic ectopic pregnancy associated with tubal mass: a case report

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Background

Ectopic pregnancy is one of the most common gynecological emergencies and accounts for 2% of all pregnancies₁. Most frequently ectopic pregnancies implant in the ampulla of the fallopian tubes however approximately 12% occur in the isthmic region₂. The pathogenesis underlying tubal ectopic pregnancy is largely unknown, although there is speculation that they may be secondary to an amalgamation of structural tubal abnormalities and tubal dysfunction₁.

<u>Case</u>

A 37-year-old woman presented with an acute onset of right lower quadrant pain associated with vaginal bleeding 7 weeks following her last menstruation. On examination she was noted to be hemodynamically stable with marked tenderness in her left iliac fossa on both abdominal and bimanual palpation. Her haemoglobin was 122 g/L and serum human chorionic gonadotropic concentration was 7650 IU/L. On transvaginal ultrasonography an intrauterine gestation sac was not detected; however a solid mass adjacent to a subserosal leiomyoma was noted to be arising from the uterine fundus (Figure 1). Medical management was offered to the patient however she declined.



Figure 3





The co-existence of tubal masses and ectopic



Figure 1

Laparoscopic examination was performed which identified an unruptured left isthmic ectopic adjoining a left subserosal comual fibroid (Figures 2-3). A left salpingectomy was performed without myomectomy. Salpingectomy was preferred over salpingostomy as the contralateral tube was normal and tubal conservation increases the risk of recurrence. Corresponding histopathology confirmed immature chronic villi and implantation site reaction in the proximal tube.



pregnancies are a rare occurrence that have been previously documented in isolated reports in the literature₃. ₅. There is evidence to suggest that tubal masses may predispose to tubal nidation of a conceptus secondary to alterations in the ciliary motion of the tubes. In the case described above, the isthmic implantation is likely attributable to proximal tubal obstruction secondary to the cornual leiomyoma. Clinicians need to exercise caution in management of ectopic pregnancies which implant in the isthmic region of the fallopian tube, as they are predisposed to rupture in the early pregnancy period due to the small lumen caliber.

Conclusion

Whilst rare, this case illustrates early pregnancies risk in patients with cornual fibroids. It also highlights the multifactorial pathogenesis leading to the implantation of an ectopic pregnancy.

References

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