An unexpected case of bilateral ectopic pregnancy from separate menstrual cycles.

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Background

Ectopic pregnancy complicates 1% of all pregnancies. It is a critical differential diagnosis in any female of reproductive age presenting with abdominal pain and a positive pregnancy test, yet many patients have a delay in diagnosis.

Case

A 27-year-old female G3P1 presented to a secondary hospital emergency department with 7 weeks of amenorrhoea and 3 days of PV spotting with central cramping abdominal pain.

Her past history included a spontaneous vaginal delivery 3 years earlier and a spontaneous miscarriage 8 months earlier. This miscarriage was never sited on ultrasound. Her menstrual cycle of 28/5 with no recent contraceptive use. Speculum examination showed an open cervical os and what was thought to be products of conception. The βHCG was 1330IU/L, Hb 135g/L. Pelvic ultrasound described echogenic debris within the uterus and she was given a diagnosis of inevitable miscarriage with discharge to GP.

The patient represented 5 days later with worsening left lower quadrant abdominal pain. She was haemodynamically stable and the βHCG was 1730IU/L. The patient received analgesia.

The histopathology was reported on day 7 showing necrotic decidualised endometrium with no evidence of intrauterine pregnancy.

Gestation (by LMP)	6+6	7+1	7+4	8+1
βHCG IU/L	1330	1636	1100	1390
Symptoms	Bleeding, cramps		Bleed	Strong pain

The patient returned 8 days after the initial presentation with more severe left sided pain. The βHCG was 1390IU/L with a right adnexal mass measuring 47x26x20mm and free fluid in the Pouch of Douglas on pelvic ultrasound.

A dilatation, curettage and laparoscopy performed found an empty uterus, a left un-ruptured tubal pregnancy and right tubal ectopic partial abortion with 300mL haemoperitoneum. A left salpingectomy and excision of right tubal mass with preservation of fimbria. The patient had an uneventful recovery.

Histopathological examination showed an intact viable left tubal pregnancy and a right sided non-viable tubal ectopic pregnancy consistent with arising from a preceding cycle.

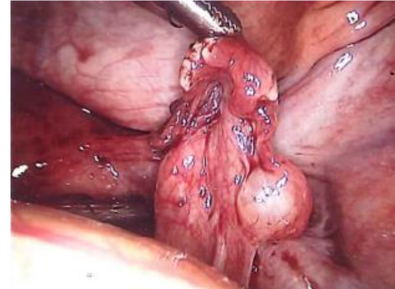

Figure 1: Right tubal ectopic pregnancy

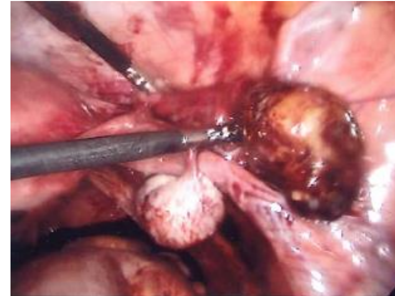

Figure 2: Right tubal ectopic pregnancy tubal abortion

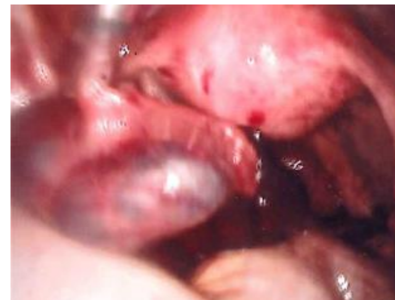

Figure 3: Left tubal ectopic with evidence of rupture

Discussion

- This case of bilateral tubal ectopic pregnancy experienced some delays in diagnosis and definitive management due to falsely reassuring examination and ultrasound findings. It is remains unclear whether this involved consecutive menstrual cycles.
- Bilateral ectopic pregnancy is very rare with an incidence estimated to be 1 per 200 000 live births, complicating between 1/725 to 1/1580 of ectopic pregnancies. [1]
- Whilst there are known risk factors such as assisted fertility techniques, tubal surgery and pelvic inflammatory disease(PID), there remains a third of patients with no identifiable risk factors.[2]
- Caution should be used when diagnosing miscarriage in the absence of a confirmed intrauterine pregnancy.
- The potential for heterotopic pregnancy should be considered in patients with atypical history and examination.
- An unremarkable ultrasound does not exclude an ectopic pregnancy especially in the absence of a sited intrauterine pregnancy.
- This case highlights the importance of universal access to Specialist Early Pregnancy Assessment Services.

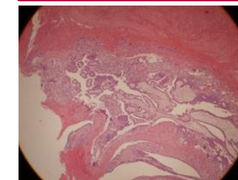

Figure 4: Histology left tube and ectopic showing viable pregnancy chorionic villi

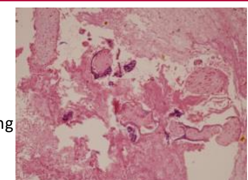

Figure 5: Histology right tubal ectopic showing degenerate chorionic villi

References

1. Savant, R., et al. (2012). "Spontaneous bilateral ectopic pregnancy: Case report." BJOG: An International Journal of Obstetrics and Gynaecology 119: 154.
2. National Institute of Health and Clinical Excellence (2012). "Ectopic Pregnancy and Miscarriage." NICE Clinical Guideline 154. Available from: guidance.nice.org.uk/cg154

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