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UNILATERAL TWIN TUBAL WITH SINGLE LIVE ECTOPIC PREGNANCY (RARE CASE)

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ABSTRACT

Unilateral twin tubal pregnancy is rare condition and it is medical or surgical emergency. Early diagnosis by clinical features and ultrasonography is essential. Misdiagnosis can be life-threatening to patients. We report a case of unilateral twin tubal with single live ectopic pregnancy which was successfully treated by salpingectomy.

KEYWORDS: Ectopic Pregnancy, Tubal twin pregnancy, Ultrasonography, Salpingectomy.

INTRODUCTION

Ectopic pregnancy (EP) is defined as implantation of pregnancy in any tissue other than the endometrium of uterine cavity. Fallopian tube (97%) is the most common site of EP including ampulla (55%), isthmus (25%), and fimbria (17%), and other 3% of EP occur in abdominal cavity, ovary, or cervix.[1] Tubal twin pregnancy has incidence of 1 :200 ectopic pregnancies and it was first reported by De Ott in 189.[2] Unilateral live twin tubal pregnancy is a very rare condition and occurs in about 1:1, 25, 000 pregnancies.[3] Early intervention i.e. diagnosis and treatment is must to prevent tubal rupture. Here we report one interesting case of unilateral twin with one live ectopic pregnancy.

CASE REPORT

Manpreet, 25 years old female G_4 P_3L_2 admitted from emergency with complaints of amenorrhoea of 1½ month, spotting per vaginum for 4-5 days and pain in abdomen for 2 days. She had a history of all previous full term vaginal deliveries.

On general examination: The patient's general condition was stable, PR – 102/min, BP 90/60mmHg, and she was afebrile. She had mild pallor and systemic examination was normal. Abdomen was soft with no guarding, tenderness or rigidity. On bimanual examination, uterus was anteverted, multiparous size, mobile with cervical motion tenderness. A tender mass about 3×2cm in size was palpable in the right fornix and left fornix was free and non-tender. Patient was kept on conservative management.

Investigations: Hb 8.2 gm%, TLC – 8000/cumm, platelet count 1lac/cumm, S. urea 22mg%, S. creatinine 0.9mg%, Random blood sugar 89mg%, Urine for routine and microscopy was normal.

Ultrasound showed right adnexal tubal pregnancy with twin gestation sac. One gestation sac shows fetal pole with cardiac activity, fluids with echoes in right iliac fossa. Left adnexa was normal and uterus was of normal size. As shown in fig 1.

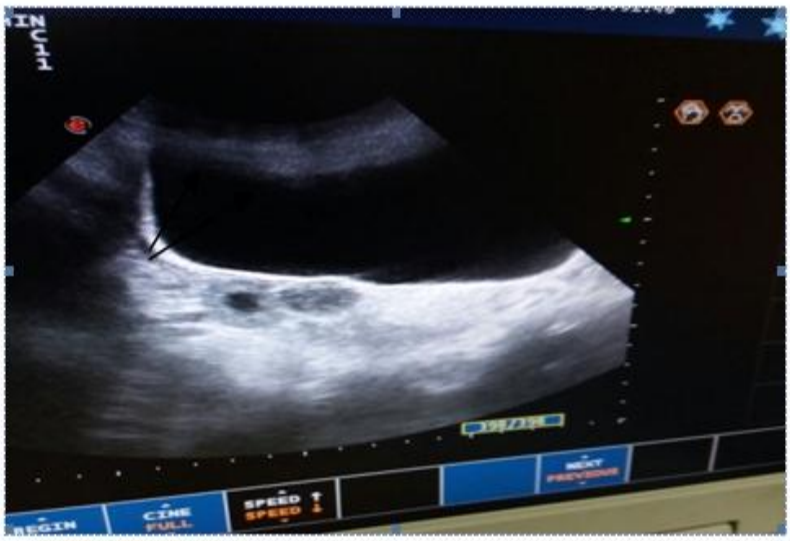
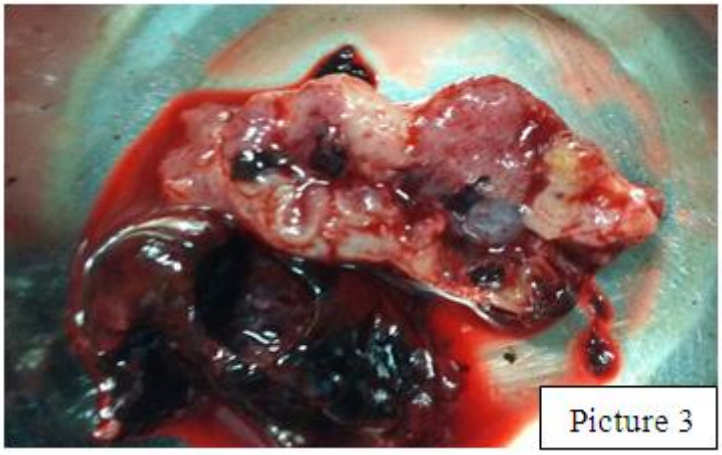


Fig.1 – shows the unilateral twin gestation sac

Emergency laparotomy with right salpingectomy with left side tubal ligation was done.

Per operative findings: Hemoperitoneum of about 400 ml with clots of 200 ml. An unruptured tubal pregnancy in right ampullary region with tubal abortion from fimbrial end was in process. Right salpingectomy was done after milking the tube. Left tubal ligation done. Uterus was of normal size with normal ovaries. Histopathological report showed two gestation sacs in right fallopian tube, as shown in picture 2 & 3.

Picture 2



Picture 3

DISCUSSION

Ectopic pregnancy in the first trimester is the leading cause of maternal morbidity and mortality specially in developing countries, Maternal death from ruptured ectopic pregnancy ranges from 10% - 15%[4] Classical triad of ectopic pregnancy is amenorrhoea, pain and vaginal bleeding. Ectopic pregnancy has several risk factors like pelvic infections, previous ectopic pregnancy, history of tubal surgery, conception after tubal ligation, use of fertility drugs, smoking and assisted reproductive technology.

Early diagnosis of ectopic pregnancy is very essential to prevent maternal morbidity and mortality as the incidence of tubal rupture is 32%and risk of rupture rises about 2.5% for every 24 hours period when untreated.[5] Use of serum β human chorionic gonadotropin (hCG), especially serial measurements and high resolution ultrasound evaluations facilitate early diagnosis of ectopic pregnancy. Serum β-hCG value of more than 1500mIU/ml suggest approximately 91.5% detection of gestational sac.[6] Suspected adnexal mass and free fluid in

pouch of Douglas in ultrasound and increased β-hCG levels along with associated risk factors can help in early diagnosis of ectopic pregnancy.

Unilateral twin ectopic pregnancies occur in 1:200 ectopic pregnancies.[7] Live ectopic twin gestations are very rare, and only 8 cases were live among > 100 reported cases of tubal twin pregnancies.[8]

After early diagnosis, treatment of choice depends upon clinical circumstances, site of ectopic pregnancies and available resources. Medical treatments include intramuscular methotrexate 1 mg/kg. Surgical treatment include salpingectomy, salpingostomy or segmental resection either by laparoscopy or laparotomy. Non – surgical treatment may be favoured in cases of tubal twin pregnancies with stable maternal vital signs and negative fetal cardiac activity suggested by Arikan et al.[9]

In our patient laparotomy with right salpingectomy and left tubal ligation was done, as ultrasonography suggested unilateral twin gestation sac with cardiac activity in one gestation sac and free fluid in pouch of Douglas. The patient was not keen to preserve fertility so ligation was done on contralateral side.

CONCLUSION

Early diagnosis and plan of treatment i. e medical or surgical can prevent maternal morbidity and mortality. Patients with unstable vitals, live cardiac activity, high risk of tubal rupture, ectopic pregnancy size > 3 cm require surgical treatment.

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