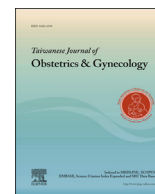




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Original Article

Laparoscopic management of ectopic pregnancies in unusual locations

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ABSTRACT

Objective: The aim of this study was to evaluate the feasibility and efficacy of laparoscopic surgery for patients with ectopic pregnancies in unusual locations.

Materials and methods: This is a retrospective case series of 31 patients from 6 weeks to 10 weeks postmenstrual who were referred for diagnosis and treatment and suspected of having an unruptured cesarean scar pregnancy (CSP) or cornual pregnancy (CP). The diagnosis was confirmed with transvaginal ultrasound, and all of the patients underwent laparoscopic management.

Results: A diagnosis of CSP or CP was confirmed in all of the patients during the laparoscopic procedure. None of the patients required conversion to laparotomy. The total operative time ranged from 40 minutes to 120 minutes. The total blood loss was limited, ranging from 30 mL to 200 mL. All of the women tolerated the operation well and had uneventful recoveries.

Conclusion: When performed by a well-trained gynecologist, laparoscopy appears to be a reasonable alternative for the treatment of unruptured CSP or CP.

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Introduction

Ectopic pregnancy is the most common cause of pregnancy-related death in the first trimester of pregnancy [1]. Ectopic pregnancies are estimated to occur in 1–2% of all pregnancies, and the majority of ectopic pregnancies are located in the fallopian tubes. Pregnancies have been reported to be implanted in the cervix, the ovaries, the cornual, interstitial tubal segments, a previous cesarean scar, and the abdomen [2]. The relative infrequency of these ectopic pregnancy sites complicates the study of treatment efficacy. Much of the knowledge regarding the treatment of these conditions is largely observational and anecdotal. Most of the cases were initially undiagnosed and then complicated with massive hemorrhaging, or they became life threatening. Physicians should maintain a high index of suspicion with a close follow-up, through which an ectopic pregnancy may be detected early. We present our experience of 31 women, all of whom were diagnosed via transvaginal ultrasound with an unruptured ectopic pregnancy in an unusual location and were treated by laparoscopic management.

Materials and methods

Patients

From July 2002 to December 2010, 258 women with a nontubal ectopic pregnancy were diagnosed at Mackay Memorial Hospital, Taipei, Taiwan. Among these, 22 women had an unruptured cesarean scar pregnancy (CSP) and nine women had an unruptured cornual pregnancy (CP). Ethical approval was obtained from the Institutional Ethics Committee of Mackay Memorial Hospital, with the approval date of September 25, 2010 and the approval number 10MMHIS114. The Institutional Review Board of Mackay Memorial Hospital approved the chart evaluation of this retrospective study. Each patient underwent a face-to-face structured interview that included questions related to her age, parity, medical illness, and previous surgery. A drug history was obtained to exclude a cause that might aggravate the symptoms. The physical examination included the height, weight, and a pelvic examination to detect the presence of an adnexal mass. Serum β human chorionic gonadotropin (β -hCG) determination was obtained in all of the patients. The diagnoses were made by the authors using transvaginal ultrasonography, and the treatments were performed by video laparoscopy. Before surgery, each woman received extensive counseling regarding the condition, the management options, the risks and benefits of treatment, further fertility concerns, and

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whether to continue the pregnancy. After counseling, each patient selected her treatment choice.

A diagnosis of CSP was made if the following sonographic criteria were met: (1) an empty uterine cavity with a clearly demonstrated endometrium; (2) an empty cervical canal; (3) a gestational sac located at the anterior part of the uterine isthmus; and (4) a gestational sac embedded in and surrounded by the myometrium and the fibrous tissue of the sac, separate from the endometrial cavity or the fallopian tube (Fig. 1A) [3,4]. A diagnosis of CP was made if a transvaginal ultrasound revealed an empty endometrial cavity and an extremely eccentrically located gestational sac surrounded by a layer of thin myometrium (Fig. 2A) [5]. Laparoscopy was performed to confirm the diagnosis and to remove the conception products. The defect in the uterus was repaired by laparoscopic suturing.

Operative procedure

Under general anesthesia, a Foley catheter was inserted to empty the bladder and monitor the urine output. With the patient

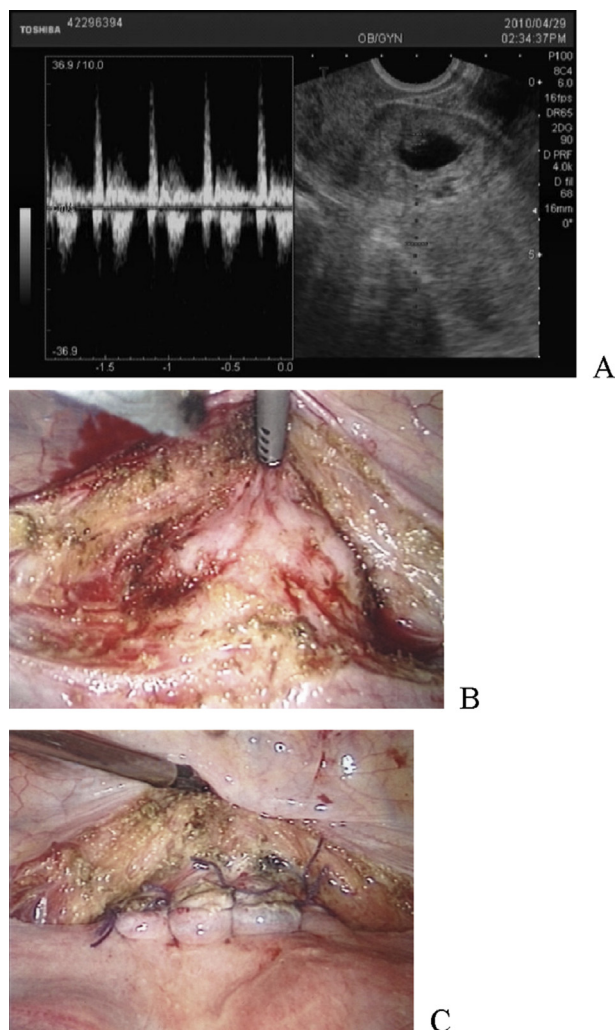


Fig. 1. (A) An ultrasound image showing a well-encapsulated, bulging mass with a gestational sac containing a yolk sac and living embryo located within the anterior uterine isthmus, in the location of a previous cesarean section scar. (B) A mass with a thin wall of myometrium and a protruding gestational sac in the area of a previous cesarean scar. (C) A single layer of interrupted 2-0 polyglactin sutures placed in the uterine wall.

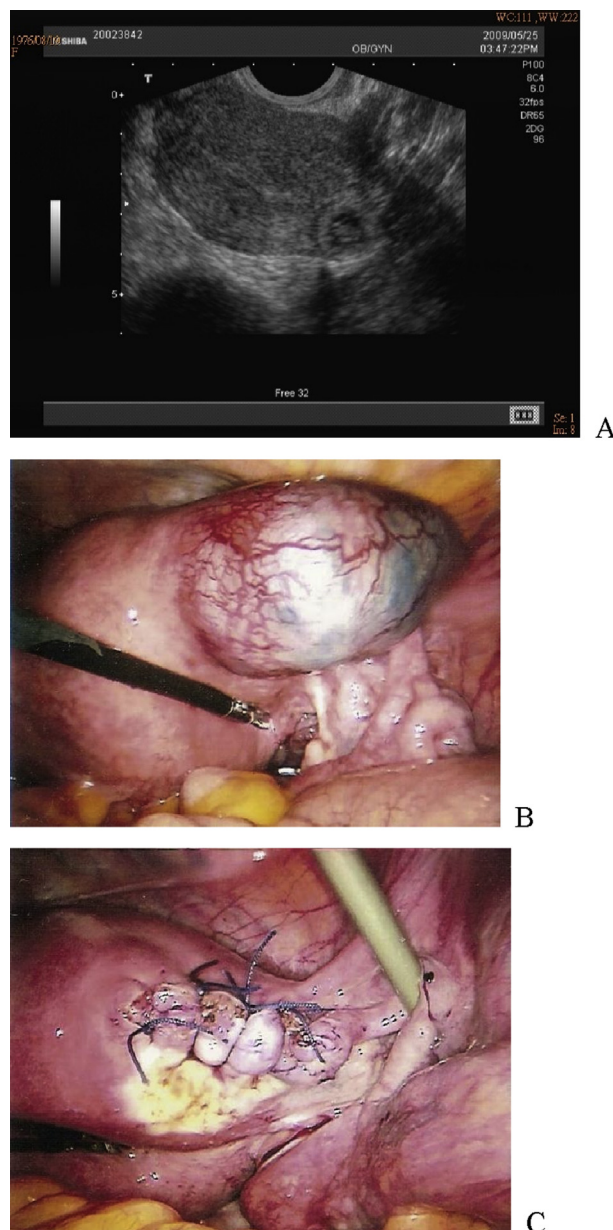


Fig. 2. (A) A transvaginal ultrasound image showing an extremely eccentrically located gestational sac and an empty endometrial cavity. (B) An extremely eccentrically located ectopic mass with increased vascularization covered with thin myometrium. (C) A single layer of interrupted 2-0 polyglactin sutures placed in the cornuostomy site.

in the supine position, a Verres needle was inserted through a small incision just inferior to the umbilicus and a pneumoperitoneum created by insufflation with carbon dioxide to a maximal pressure of 20 mmHg. Then, a 10-mm operative trocar was inserted into the abdominal cavity. A laparoscope with an attached video camera was passed through the cannula to visualize the intra-abdominal organs with simultaneous recording. The patient was placed in the 15° Trendelenburg position. A 5-mm trocar was inserted suprapubically in the midline and passed into the pelvic cavity, and two additional 5-mm trocars were inserted at the level of the anterior superior iliac spine, lateral to the epigastric blood vessels. After placement of the trocars, the intra-abdominal pressure was decreased to 15 mmHg. A laparoscopic assisted vaginal hysterectomy (LAVH) or conversion to laparotomy was performed if massive bleeding occurred.

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