

Sigmoid Microinvasion by an Ectopic Pregnancy

Joalee Paquette, MD, Mathieu Leboeuf, MD, FRCSC, MPH, Émilie Gorak-Savard, MD, FRCSC

Department of Obstetrics, Gynecology and Reproduction, Université Laval, Québec QC

Abstract

Background: Approximately 2.1% to 8.6% of all pregnancies after IVF with embryo transfer have been reported to be ectopic. In this report, we present a case of presumed intestinal microperforation caused by an ectopic pregnancy following IVF.

Case: A 29-year-old woman presented with rectal bleeding. She had previously been treated for an ectopic pregnancy for which she had received two doses of methotrexate. Colonoscopy and abdominal CT angiography were performed and showed that the ectopic pregnancy was attached to the sigmoid colon. Surgery was performed to remove the ectopic pregnancy. Because intestinal microperforations were suspected, the patient received intravenous antibiotic therapy during her hospitalization.

Conclusion: In cases of intestinal bleeding, clinicians should consider the possibility of intestinal involvement of an ectopic pregnancy, even if the response to treatment for the ectopic pregnancy has been appropriate.

Résumé

Contexte : On a affirmé qu'environ 2,1 % à 8,6 % des grossesses découlant d'une fécondation in vitro (FIV) avec transfert d'embryon sont des grossesses extra-utérines. Dans le présent rapport, nous exposons un cas de microperforation intestinale présumée attribuable à une grossesse extra-utérine à la suite d'une FIV.

Cas : Une femme de 29 ans s'est présentée à l'hôpital avec des saignements rectaux. Elle avait auparavant été traitée pour une grossesse extra-utérine, pour laquelle on lui avait administré deux doses de méthotrexate. Une coloscopie et une angiographie abdominale par tomodensitométrie ont montré que la grossesse extra-utérine avait créé des adhérences avec le côlon sigmoïde. On a extrait la grossesse extra-utérine par chirurgie. Parce que l'on soupçonnait des microperforations intestinales, la patiente a reçu une antibiothérapie par intraveineuse durant son hospitalisation.

Conclusion : Dans les cas d'hémorragie intestinale, le clinicien doit envisager la possibilité d'une atteinte intestinale liée à une

grossesse extra-utérine, et ce, même si la grossesse extra-utérine a bien répondu au traitement.

Copyright © 2016 The Society of Obstetricians and Gynaecologists of Canada/La Société des obstétriciens et gynécologues du Canada.

Published by Elsevier Inc. All rights reserved.

J Obstet Gynaecol Can 2016;38(11):1033–1036

INTRODUCTION

The incidence of ectopic pregnancy is estimated to be 1% to 2% of all pregnancies. Major risk factors include prior tubal ligation, previous tubal surgery, previous ectopic pregnancy, current IUD use, and IVF. Approximately 2.1% to 8.6% of all pregnancies after IVF with embryo transfer have been reported to be ectopic.^{1–3} The typical symptoms of an ectopic pregnancy are amenorrhea and subsequent vaginal bleeding and abdominal pain. However, 50% of women with a tubal pregnancy are asymptomatic before tubal rupture.⁴

In this report, we describe a unique case of presumed intestinal microperforation caused by an ectopic pregnancy that followed IVF and embryo transfer.

THE CASE

A 29-year-old primigravid woman presented at 6+2 weeks' gestation with mild abdominal pain and suspicion of ectopic pregnancy following IVF and embryo transfer. She had a three-year history of infertility due to multiple factors (male, ovulatory, tubal, and peritoneal factors). She had had a cecal perforation nine years earlier due to Crohn disease and had undergone ileal resection and drainage of an intra-abdominal abscess. Following this, she had required percutaneous drainage of recurrent intra-abdominal abscess on two occasions.

Subsequently, hysterosalpingography showed a right hydrosalpinx, and laparoscopic right salpingectomy with

Key Words: Ectopic pregnancy, methotrexate, single-dose methotrexate, in vitro fertilization, intestinal microperforations

Competing Interests: None declared.

Received on April 22, 2016

Accepted on May 31, 2016

<http://dx.doi.org/10.1016/j.jogc.2016.07.006>

adhesiolysis was performed. Semen analysis had shown moderate asthenozoospermia and moderate teratozoospermia, and she underwent eight cycles of intra-uterine insemination without success.

At the time of presentation, serum human chorionic gonadotropin was 767 IU/L, and transvaginal sonography showed an empty uterine cavity and no free intra-abdominal fluid. She was discharged and scheduled for a follow-up visit two days later to repeat the assay of serum β -hCG.

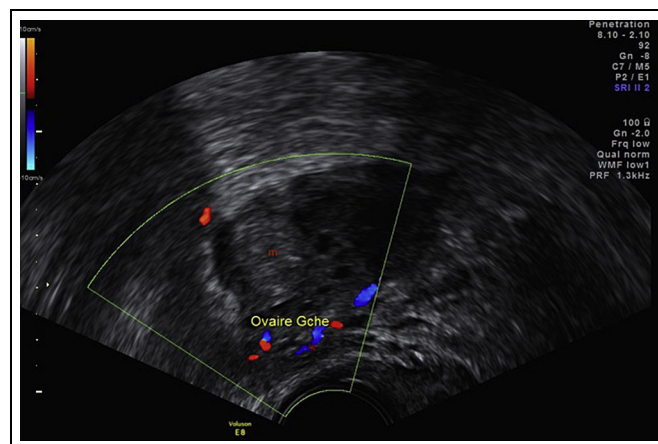
At follow-up, the β -hCG level had increased to 1153 U/L. Because this was a much-desired pregnancy, expectant management was followed, and a repeat β -hCG assay was scheduled for two days later. Because she was Rh negative, she was given prophylactic anti-D (120 μ g, intramuscular).

Two days later the β -hCG level was 1598 IU/L. Transvaginal ultrasound again showed an empty uterine cavity and no free intra-abdominal fluid. Endometrial biopsy was performed and no trophoblastic tissue was seen on histological assessment, leading to a presumptive diagnosis of ectopic pregnancy. After counselling and laboratory assessment, the patient received a single IM dose of methotrexate 50 mg/m².⁵ Her hemoglobin concentration was 123 g/L, hematocrit 0.37, platelet concentration 329×10^9 /L, serum creatinine 61 μ mol/L, serum Alanine Aminotransferase 9 U/L, and serum alkaline phosphatase 55 U/L. She was discharged and was advised to return if her abdominal pain worsened.

At a scheduled visit one week later, the serum β -hCG level had increased to 1953 IU/L, and transvaginal ultrasound assessment showed an empty uterine cavity and no free intra-abdominal fluid. A second dose of methotrexate 50 mg/m² IM was given.^{6,7} One week later, the β -hCG level had decreased to 775 IU/L. Repeat transvaginal ultrasound showed a left para-ovarian mass measuring 17 \times 15 mm, with no free intra-abdominal fluid (Figure 1). Weekly assays of serum β -hCG were scheduled, to continue until negative.

Two weeks after her second dose of methotrexate, the patient returned with abdominal pain. Her β -hCG level was 399 IU/L. She was hospitalized for two days because of her level of pain; repeat transvaginal ultrasound showed a 23 \times 47 \times 64 mm intra-abdominal fluid collection and

Figure 1. Transvaginal sonography showing a left para-ovarian mass of 17 \times 15 mm. m: mass; ovaire gche: left ovary



an increase in the size of the left para-ovarian mass to 24 \times 19 \times 14 mm. After 48 hours of hospitalization, the patient was discharged because she was asymptomatic, her β -hCG level was stable, she was reliable, and she lived close to the hospital. Five days later, her β -hCG level was 112 IU/L and she was asymptomatic.

After a further three days, the patient presented with diarrhea and rectal bleeding. Because of her known Crohn disease, a gastroenterologist was consulted. Her hemoglobin concentration was 87 g/L, and she had active rectal bleeding, and accordingly, she received a transfusion of packed red blood cells. Her β -hCG level was 42 IU/L. Urgent colonoscopy was performed, and blood was seen throughout the lumen of the colon to the ileum (Figure 2). No mass, ulceration, or other source of bleeding was seen. Gastroscopy was performed to exclude bleeding from the upper gastrointestinal tract, and no abnormality was identified.

Abdominal CT angiography was then performed to localize the bleeding site (Figure 3). This showed a left adnexal lesion (3.7 \times 3.4 \times 4.8 cm) in contact with the sigmoid wall at two points (proximal sigmoid and mid-sigmoid). No thickening of the sigmoid wall was seen. In view of this, the patient was reassessed by a gynaecologist; in view of the possibility of a sigmoid fistula, laparoscopic assessment was planned, with support from a general surgeon in the event that bowel resection was required.

At laparoscopy, the right ovary appeared normal, and the right fallopian tube was absent. The left ovary was initially obscured by multiple adhesions and a mass abutting the sigmoid colon. The sigmoid was coated with clotted blood and its serosa was inflamed. Proctoscopy was then

ABBREVIATIONS

β -hCG human chorionic gonadotropin
IM intramuscular

Download English Version:

<https://daneshyari.com/en/article/5695939>

Download Persian Version:

<https://daneshyari.com/article/5695939>

[Daneshyari.com](https://daneshyari.com)