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## Short Communication

## Ectopic pregnancy – Review of 80 cases

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## ABSTRACT

**Background:** Ectopic pregnancy or extrauterine pregnancy will invariably result in abortion or rupture. Though there are risk factors for ectopic pregnancy, but at times the condition can occur without any apparent predisposing factor. Cases admitted with provisional diagnosis of ectopic pregnancy were included in this prospective study.

**Methods:** Eighty suspected cases of ectopic pregnancy were incorporated in the study. The management was done based on standard practice. All the cases underwent urine pregnancy test, routine blood investigations including blood group, and transvaginal ultrasound. Serial  $\beta$ hCG was measured in cases where the diagnosis was not clear initially.

**Results:** Incidence of ectopic was 2.46 per 100 deliveries; there was no apparent risk factor in 28.7% and many cases had more than one risk factor. 'Triad' of ectopic was present in only 21 cases. Sixteen cases were asymptomatic and two were admitted as emergency. Ultrasound findings were inconsistent and wide ranging. In 37 doubtful cases,  $\beta$ hCG was measured serially.

There was one case of suspected interstitial pregnancy confirmed on laparoscopy. Twenty-seven cases were managed medically, and 9 were managed expectantly. Forty-six cases were managed surgically either by laparoscopy or by laparotomy. Salpingectomy was performed in 37 cases, and salpingostomy in 7 cases either laparoscopically or by laparotomy.

**Conclusion:** Ectopic pregnancy can be managed by laparotomy, operative laparoscopy, and medically and occasionally by observation alone. Management must be customized to the clinical condition and needs of future fertility of the patient.

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## Introduction

Ectopic pregnancy or extrauterine pregnancy is defined as implantation and subsequent development of the zygote at a site other than normal intrauterine cavity.<sup>1</sup> Uterus alone is

designed to accommodate the fetus and its growth. When zygote is implanted in other places, it will not be able to grow normally and hence will always result in abortion or rupture. Very rarely the fetus can continue to grow in peritoneal cavity (abdominal pregnancy) even after tubal rupture resulting in a term fetus. The most common site of ectopic pregnancy is the

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fallopian tube, and the cause of zygote implanting into the tube is not always clear<sup>2</sup> though it is postulated to be functional or anatomical tubal damage in most of the cases. At times, the condition can occur without any apparent predisposing factor. Incidence of ectopic pregnancy has been increasing<sup>3</sup> but mortality has been declining continuously as many cases are diagnosed early and before rupture. Early diagnosis is made on algorithms which are based on high resolution transvaginal ultrasound (TVS) and quantitative estimation of serum  $\beta$ hCG measured initially and sometimes serially. Changes in the levels of  $\beta$ hCG can be used to predict ectopic pregnancy.<sup>4</sup> The rising incidence is attributed to early diagnosis, increased incidence of pelvic inflammatory diseases, and assisted reproductive techniques.

## Material and methods

This prospective study was conducted at a tertiary care hospital over a period of 1 year and 2 months from November 2014 to December 2015. All cases admitted with diagnosis of ectopic pregnancy were incorporated in the study, and a total of 80 cases were included in the study, their data collected and compiled. End point of the case was when ectopic pregnancy had undergone definitive treatment, either medical or surgical, or when ectopic pregnancy was ruled out. All the cases underwent urine pregnancy test and routine blood investigations including blood group and TVS. Serial  $\beta$ hCG was measured in cases where the diagnosis was not clear initially. The management was done based on standard practice; cases on expectant management were in the study till the serum  $\beta$ hCG became undetectable. The findings and results are as under.

## Results

There were 3214 deliveries during the period of study; during this period, there were 80 cases admitted with diagnosis of ectopic pregnancy thereby indicating the incidence of ectopic as 2.46 per 100 deliveries, being slightly higher as compared to 1 in 161 deliveries as reported by Arup et al.<sup>5</sup> This increase in the incidence was probably due to the hospital being a referral center. Age distribution was uniform and unremarkable except that below 20 and above 40, the incidence was extremely low.

Ectopic pregnancy is likely to occur more commonly in women who have certain risk factors as listed in Table 1. There were 37 cases of infertility; of both primary and secondary; primary was more common. There was one case of tubal sterilization and tuboplasty each. Many times, there is no risk factor as it was noticed in this series; there was no risk factor in 23 cases (28.7%) and many cases had more than one risk factor. Only 21 cases had all the three symptoms of ectopic pregnancy, traditionally called 'Triad of Ectopic'. These days, many cases have atypical clinical presentation as suggested by many authors.<sup>6</sup>

Clinical presentation is shown in Table 2. Sixteen cases did not have any symptom but were picked up on routine first trimester scan or on follow-up of infertility cases undergoing

**Table 1 – Risk factors detected.**

S. no.	Risk factor	n (%)
1	Primary infertility	24 (30.0)
2	Secondary infertility	18 (22.5)
3	Ovulation induction	06 (7.5)
4	IUI	11 (11.7)
5	IVF-ET	12 (15.0)
6	CS	06 (7.5)
7	Tubectomy	01 (1.25)
8	Past ectopic	02 (2.5)
9	History of abortion	11 (11.7)
10	History of PID	09 (11.2)
11	Myomectomy	01 (1.2)
12	Tuboplasty	01 (1.2)
13	Appendectomy	02 (2.5)

**Table 2 – Clinical presentation.**

S. no.	Finding	n (%)
1	Amenorrhoea	68 (85)
2	Bleeding PV	57 (71)
3	Pain abdomen	42 (58)
4	Vomiting	09 (11)
5	Loose motions	01 (0.01)
6	Fainting attacks	04 (0.05)
7	Shoulder tip pain	02 (0.02)
8	Hypotension	3 (0.03)
9	Palpable adnexal Mass	27 (33)
10	Cervical motion tenderness	31 (38)
11	Asymptomatic	16 (20)

treatment including in vitro fertilization and embryo transfer (IVF-ET). Two cases were admitted as emergency with pain abdomen and hypovolumic shock. Urine pregnancy test was positive in 61 cases, negative in 13, and weakly positive in 6 cases as shown in Table 3. Urine pregnancy test does not always diagnose or exclude ectopic pregnancy. Ectopic pregnancy still can be there even when urine pregnancy test is negative. Sonography findings in a suspected or confirmed ectopic pregnancy are inconsistent and wide ranging (Table 4). It may vary from being absolutely normal to clear-cut evidence

**Table 3 – Urine pregnancy test.**

S. no.	Result	n (%)
1	Positive	61
2	Negative	13
3	Weakly positive	06

**Table 4 – Transvaginal ultrasound findings.**

S. no.	Finding	n (%)
1	Empty uterine cavity	77 (1.2)
2	Intrauterine pregnancy	02 (23.7)
3	Pseudosac	03 (26.2)
4	Live extrauterine fetus	03 (28.7)
5	Isolated POD fluid	45 (18.7)
6	Intra abdominal fluid	02 (1.2)
7	Simple ov cyst	03 (3.7)
8	Complex adnexal mass	42 (52)
9	Fibroid	04 (5.0)

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