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Yonghee Cho, MD, Susan Henning, MS, Gerald Harkins, MD

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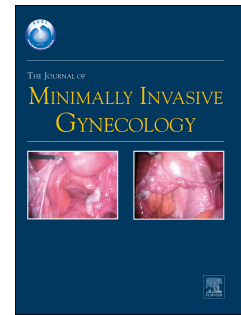
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Yonghee Cho, MD, Susan Henning, MS, Gerald Harkins, MD

From the Department of Obstetrics and Gynecology, Division of Minimally Invasive Surgery, Milton S. Hershey Medical Center, Penn State, Hershey, Pennsylvania

The authors declare that they have no conflicts of interest.

Corresponding author:

Yonghee Cho, MD, Penn State, 500 University Drive, Mail Code H103, PO Box 850, Hershey, PA 17033

E-mail: ycho2@pennstatehealth.psu.edu

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A 35-year-old woman, G4P3013, presented to the emergency room with pelvic pain and vaginal bleeding status post postpartum tubal ligation. Beta human chorionic gonadotropin was 8271 million IU/mL. Transvaginal ultrasound revealed enlarged right fallopian tube with a 1.5 x 3.0 x 2.5 cm gestational sac with a 5-mm fetal pole consistent with ectopic pregnancy.

Laparoscopic evaluation revealed a right broad ligament ectopic pregnancy. Extensive vascular implants to the infundibulopelvic ligament were noted. Ureterolysis was performed and the infundibulopelvic ligament was transected, necessitating an oophorectomy. The pregnancy abutted the uterus and involved the uterine artery. This required a partial cornual resection of a portion of the uterine serosa to safely remove the ectopic pregnancy en bloc. The patient's contralateral fallopian tube appeared consistent with her history of a postpartum tubal ligation. Given the risks of a second ectopic pregnancy and the patient's lack of desire for continued fertility, the decision was made to proceed with a bilateral salpingectomy.

Broad ligament or interligamentous pregnancy is extremely rare and thought to occur in 1 of 300 ectopic pregnancies [1]. Diagnosis typically occurs at the time of surgery and is based on anatomic boundaries of a medial uterus, lateral pelvic sidewall, inferior pelvic floor, and superior fallopian tube [2]. Owing to the proximity to the pelvic sidewall and uterus and potential involvement of the surrounding pelvic structures, patients should be counseled preoperatively on the increased risk of damage to the structures as well as the possibility of an oophorectomy. If needed, the surgeon should be prepared to suture laparoscopically. In patients who have completed childbearing, removal of the contralateral tube should be considered.

Figures:

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