

ECTOPIC GESTATION: UTILITY OF ULTRASONOGRAPHY.

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INTRODUCTION

Estimates of the death rate from ectopic gestation are about one in 1000 cases.¹ The first documented autopsy performed in USA circa 1638 or 1639, identified an ectopic pregnancy as the cause of death. This disease can result in the death of young women of child-bearing age who are otherwise free of diseases and in whom eradication of the ectopic pregnancy ends their current risk. Ultrasound is utilized in diagnosing ectopic gestation as depicted in the case reported below.

Indexing words: Ectopic pregnancy, ultrasonography.

CASE REPORT

A young lady aged 25 years having regular menstrual cycle, came to the hospital with the complain of severe lower abdominal pain. On examination she was toxic with shrunken eye, pulse: thready, 120/minute, anemia: severe, B.P. 90/70 mm Hg in spite of blood transfusion, lower abdomen was tender with slight vaginal bleeding. Progressively her condition deteriorated. On P/V examination, uterus was normal in size and on other abnormality could be detected. Ultrasono-

graphy revealed normal-sized uterus, uniform in echotype. There was a collection of fluid in the pouch of Douglas and also in the upper abdomen including Morrison's pouch and flanks raising the suspicion of ruptured ectopic (tubal) pregnancy. On laparotomy, left fallopian tube was seen ruptured and remnants of products of conception was present in it. Salpingectomy was done and consequently the patient improved. Of interest, the patient had no history of amenorrhoea. (Fig.1)

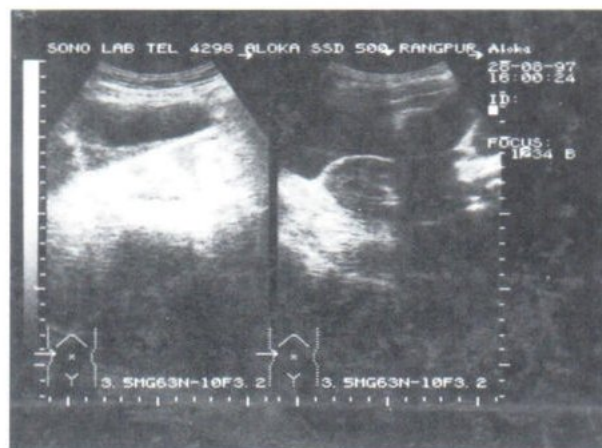


Fig.1 Ectopic gestation : Utility of ultrasonography

DISCUSSION

Laparoscopy is the single-most accurate method of confirming ectopic gestation before surgery. However, routine use of laparoscopy in suspected ectopic pregnancy is impractical as it is highly invasive and not available everywhere, Culdocentesis, although less invasive, negative aspiration are unreliable for excluding an ectopic gestation. Concomitant intrauterine pregnancy and ectopic gestation occurs and the incidence is increasing due to ovulation induction procedures (e. g. Clomiphene therapy), the rate of concomitancy is quoted usually² as one per 30000 and in patients undergoing ovulation induction to be as high as one per 7000 pregnancy.³ Sonography is useful non-invasive method as the menstrual history may be misleading as in the present case reported here. Ectopic pregnancies produce HCG (human chorionic gonadotropin) at a slower rate than normally implanted pregnancies.⁴ The natural history of ectopic gestation almost certainly includes those fetuses that implant, die and are reabsorbed without being clinically recognized. But a clinician cannot count on this probability in any given case. Among women who have had an

ectopic gestation, the subsequent overall conception rate is about 60%, of these 50% are intrauterine and 10% are repeat ectopic pregnancy, 97% of ectopic gestations are tubal in location.

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