
CASE REPORT

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CASE 1 OVARIAN PREGNANCY

Here we present a case of a 30-year-old woman with right ovarian pregnancy who came with a history of amenorrhoea for the last six months and in the early stage she had all the minor ailments of pregnancy i.e. nausea, vomiting, morning sickness etc. Previously urine for pregnancy test was done and found to be positive elsewhere with a palpable lower abdominal mobile mass. On examination, there was a mobile pelvic mass of about 17 weeks pregnancy. No foetal movement, no foetal heart sound was detected, her pulse was 88/min and blood pressure was 135/85 mm Hg and she was mild anaemic. She was diagnosed as having an ovarian tumour elsewhere and sent for ultrasonography of the pelvic organs. In ultrasonography we found that uterus is slightly enlarged in size and shape, normal in position. There is a large gestational sac with all the product of conception in it, outside the uterus, very close to the anterior abdominal wall. foetal heart movement was absent and spalding of skull bones were seen. The case was diagnosed as intra-abdominal, extrauterine pregnancy, which later on, was confirmed by laparotomy. Gestational age was calculated by femoral length of the foetus and it was about 18 weeks gestation. During laparotomy it was found that there is a large, soft mass in the pelvic cavity, clearly separated from the other intra-abdominal organs but attached to the right ovary. Within the mass we found all the foetal parts, amniotic fluid and placenta. Uterus is almost normal in size, shape and position. All the products were removed and right-sided salphingo-oophorectomy were done and the case was diagnosed finally as right-sided ovarian pregnancy.

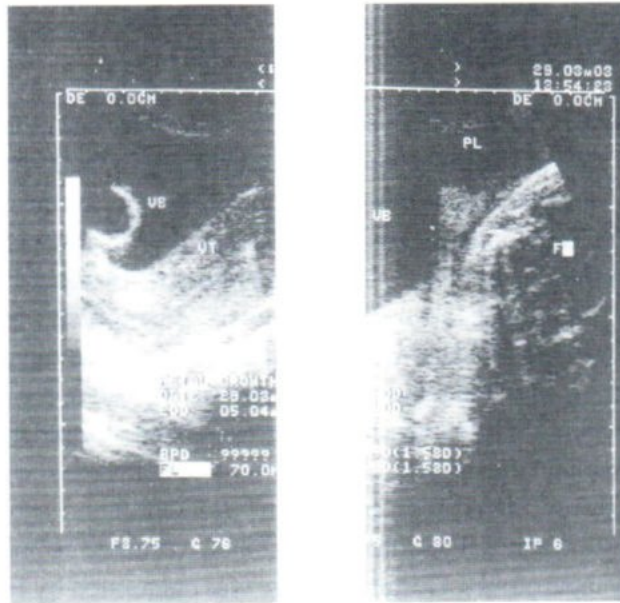
CASE 2 INTRA - ABDOMINAL PREGNANCY.

A multi-gravida aged about 33 years came with a history of amenorrhoea for 9 months without feeling of foetal movement. On general physical examination she was mild anaemic, pulse was 80/min and blood pressure was 140/80 mm Hg. Abdominal examination revealed 35 weeks size fundal height, no foetal movement and no foetal heart sound but the foetal parts were palpable very superficial near to the abdomen. Ultrasound had been done elsewhere and the case was diagnosed as intra-uterine foetal death of about 33 weeks size. Then she was hospitalized for induction of labour. The obstetrician had tried for induction of labour but failed, then she was sent for ultrasonography once more in our center. We found that the uterus was normal in size, shape, but low in position, low-placed. There is a large foetus in an amniotic cavity, outside the uterus, very close to the anterior abdominal wall. Spalding of foetal skull bones were present, foetal heart movement was absent. Amniotic fluid was almost adequate in amount and placenta was located posteriorly and maturity grade-III. The case was

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diagnosed as extra-uterine pregnancy, which later on the diagnosis was confirmed by laparotomy. During laparotomy it was found that, a dead, foetus with others product of conceptions were visualized in the amniotic cavity, outside the uterus, clearly separated from the others intra-abdominal organs and having attachment with the right ovary. All the products were removed and oophorectomy was done.



INTRODUCTION

The incidence of ectopic pregnancies has steadily increased from 4.5/1,000 in 1970 to 20/1,000 in 1992¹ prior to 1978 only 28% of ectopics were diagnosed prior to rupture; this figure had changed to be 85% by 1988^{2,3} Ectopic pregnancy is still a major cause of maternal mortality. The maternal mortality associated with an ectopic pregnancy is ten times greater than that associated with childbirth.⁴

It is more common with advancing maternal age and lower social class. History of pelvic diseases, uses of an IUCD, pelvic pain, metrorrhagia are associated with ovarian pregnancy.

DISCUSSION

Ovarian pregnancy is an uncommon type of ectopic pregnancy. Incidence has been estimated at 1 per 7 000 pregnancies and 1 to 6% of ectopic pregnancies. Pathogenesis is different from tubal

pregnancy. Generally it occurs as a single event in an otherwise healthy woman.

The most common site is the fallopian tube, although implantation can occur in the cornu, the cervix, the ovary and the abdominal cavity.⁶

Approximately 80% of ectopic pregnancies occur in the ampullary portion of the fallopian tube; 10% are in the isthmus; 5% are fimbrial in location and 2-4 % are cornual. Ovarian, cervical and abdominal pregnancies are rare.⁷

Ovarian pregnancy is a rare type of ectopic pregnancy, which is difficult to be diagnosed clinically, but its incidence is certainly underestimated.⁸

Ovarian pregnancies resulted from either ovum fertilization within the ovary (primary) or the implantation of a tubal abortion on an ovary

(secondary). The sonographic appearance of an ovarian pregnancy can vary from an "echogenic ring" fixed to the ovary to a complex adnexal mass that involves the ovary. It may, therefore, be difficult to distinguish a hemorrhagic ovarian cyst from an ovarian pregnancy.⁹

Since the fallopian tube is not affected, an ovarian pregnancy is not a risk factor for a repeated ectopic pregnancy.

An abdominal pregnancy occurs when a tubal abortion implants on a peritoneal cavity and continues to grow. While anhydramnios is common, it is not an invariable finding with abdominal pregnancies. Additional sonographic signs include a failure to visualize the uterine wall around a pregnancy; an abnormal fetal lie; and an empty uterus with an adjacent fetus. A pregnancy in one horn of a bicornuate or didelphic uterus may mimic an abdominal pregnancy.¹⁰

In most cases ovarian pregnancy mimics adnexal mass. This case was diagnosed as ovarian tumour clinically. So any adnexal mass before excision should have to use an ultrasound scanning for diagnosis.

It can be concluded that, the valuable information obtained by proper ultrasound scanning can reduce unnecessary delay in the management of many diseases, thereby relieving the patient from many morbid conditions.

Most are agreed that USG should be used as the first means of study for detection of an extra-uterine pregnancy, where TVUS facilities are not available, as it is non-invasive, hazardless and cost effective.

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