



Ruptured Ovarian Pregnancy in A Young Primigravida

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ABSTRACT

Primary ovarian pregnancy is one of the rarest variety of ectopic pregnancy accounting for 0.15-3% of all ectopic gestations. Heartig estimated that ovarian pregnancy occur in 1 in 25000-40000 pregnancies. Pre operative diagnosis is challenging and needs high index of suspicion. In any case of ruptured ectopic pregnancy where tubes are found to be normal on laparotomy an ovarian pregnancy must be ruled out. We report such a rare case of ruptured ovarian pregnancy diagnosed on laparotomy which was later on confirmed by histopathological examination.

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Introduction

Ectopic pregnancy is one of the most common gynaecological emergencies and accounts for 10% of all maternal mortality^[3] and most common cause of maternal mortality in first trimester^[4]. Most common location of ectopic pregnancy is fallopian tube but in some cases it can be ovarian. The diagnosis of an ovarian ectopic pregnancy is often made at surgery and requires histological confirmation as it is difficult to differentiate it from a hemorrhagic corpus luteum intraoperatively^[5]. Ovarian pregnancy is a rare diagnosis of exclusion made after laparotomy followed by histopathological examination as it was in our case.

Case Report

A 21 yr old young primigravida married for 4 months came to emergency of Rajindra Hospital Patiala with complaint of pain abdomen with vomiting and spotting per vaginum. There was no h/o preceding amenorrhoea but there was h/o scanty periods during last menses which was 15 days back. Her previous cycles were regular with 3-4 days of bleeding every 28-30 days with average flow and no dysmenorrhoea. There was no h/o any contraceptive use or ovulation induction. On examination her BP was 90/60 mm of Hg, Pulse 110/min, feeble, Pallor was +++, on P/A there was tenderness in right iliac fossa with rigidity and guarding all over abdomen. Her UPT was positive. Paracentesis done and there was frank hemoperitoneum. Patient was taken for immediate laparotomy with a pre-operative provisional diagnosis of right ruptured tubal pregnancy.

Emergency laparotomy was performed. Intra operative there was massive hemoperitoneum, about 2.5 litres of blood drained from peritoneal cavity. Both the tubes were found to be normal. Left ovary was normal. The right ovary was enlarged ms about 4.5cm x 4cm, there was one cyst and some irregular mass from the surface of which blood was oozing. Right fallopian tube was found completely normal and separate from the ovary. Wedge resection of bleeding tissue was done. Stitches applied, complete hemostasis obtained. Tissue was sent for histopathological examination. Histopathological examination done wide no. H-710/15, which showed chorionic villi with decidualised ovarian stroma suggestive of ovarian pregnancy.

Discussion

Primary ovarian pregnancy is one of the rarest type of extrauterine pregnancies^[6]. Some of the cases are associated with factors such as IUCD^[7], ART, endometriosis and PID^[8]. Our patient did not have any of the risk factors and present pregnancy had occurred in a spontaneous cycle.

The proposed hypothesis for ovarian ectopic are non release of ovum from ruptured follicle, tubal malfunction and inflammatory thickening of tunica albuginea. There is often a delay in diagnosis as gestation sac mimics corpus luteum, haemorrhagic cyst and endometriotic cyst of ovary^[7]. Patient was misled by scanty periods so could not seek advice for her 6 weeks amenorrhoea before she presented in emergency with ruptured ectopic pregnancy. Clinicians should be aware of difficulties with clinical, radiological and intra operative diagnosis.

With a few exceptions initial diagnosis is made on operating table and final diagnosis only on histopathology on basis of four Spiegelberg's criterias^[9]

1. The fallopian tube on affected side must be intact.
2. Fetal sac should occupy the position of ovary.
3. Ovary must be connected to uterus by ovarian ligament.
4. Ovarian tissue must be located in sac wall.

Early diagnosis of unruptured ovarian pregnancy with TVS which is usually rare allows for conservative management with methotrexate. However if the diagnosis is made later in case with ruptured ovarian pregnancy local resection of bleeding mass with conservation of ovary is usually done. Even if the last trophoblastic villi cannot be removed it will usually degenerate spontaneously or respond to post operative methotrexate therapy producing no long standing clinical problem^[10]

No case of recurrent ovarian pregnancy has been reported in contrast to 15% risk of recurrence of tubal pregnancy^[11]. Fertility after ovarian pregnancy remain unmodified^[12].

Conclusion

Primary ovarian pregnancy may occur without presence of any of classical risk factors or symptoms/signs. Early diagnosis and treatment can help in conservative management and retain the future fertility of the patient.

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Competing Interests

None declared

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