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Research Article

RECENT TRENDS IN ECTOPIC IN APOLLO HOSPITAL COINCIDENCE OR RISING TRENDS? A CROSS SECTIONAL STUDY

SanchitaDubey and VarnikaRastogi

Department of Obstetrics and Gynaecology Apollo Hospital

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ABSTRACT

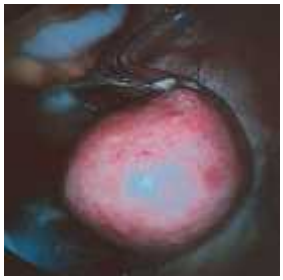
Introduction: Ectopic pregnancy accounts for 2% that of live births in developing countries though it may be high as 4% in ART group.
It is most common cause of death during the first trimester approximately 10%.
Risk factors includes PID, Tabacco smoking, prior tubal surgery, increased maternal age, use of assisted reproductive technology.
Early diagnosis and prompt treatment is key to reduce morbidity and mortality due to this condition.
Aim &Objective: To study trend in ectopic pregnancy in Apollo hospital.
Method: This is a cross sectional study in month of July2016 all those who were diagnosed to have ectopic pregnancy on USG and with B HCG values are included in study
Result: From June 2015 to June 2016 (1 Year).
Total no of surgically managed cases -7
Total no of medically managed cases -5.Total -12
In month of July 2016 total no of ectopic- 9
Incidence of ectopic has increased in one month and also it has presented with varied clinical features and early diagnosis and prompt treatment has reduced mortality in these patients.
Conclusion: Since cases are rising and the presentation for this condition may vary but vigilant and prompt action is required to prevent any complication and to ensure the healthy outcome.

INTRODUCTION

Case:1 Surgical Management of Ectopic Pregnancy

33years G4P2L2E1 at 6weeks came with pain left lower abdomen since two days and spotting P/V since3-4days.
LMP-23/5/16
UPT positive on 4/7/16
USG (4/7/16) unruptured left ectopic pregnancy ET-11mm,no gestational sac in uterine cavity .Probe tenderness +
OBSTETRIC H/O: Patient had two normal deliveries and one ectopic pregnancy before which was medically managed
PLAN: Patient also wanted family planning operation thus proceeded to surgical management.
Laparoscopic left salpingectomy with right tubal ligation and D&C
FINDING:(shown in figure -1)
Uterus bulky upto 6weeks period of gestation.
Left tube dilated with ectopic pregnancy seen with small clots seen at fimbrial end
Right tube normal
B/L ovaries normal
POD-Heamoperitoneum +minimal blood collection seen in POD

LEFT TUBE

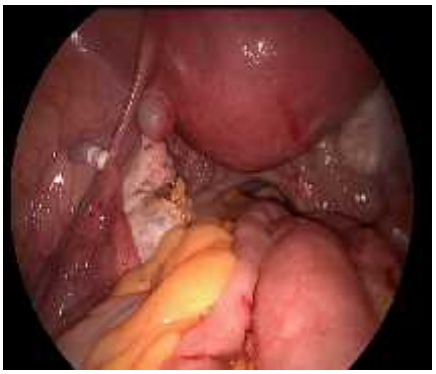


RIGHT TUBE
Figure-1

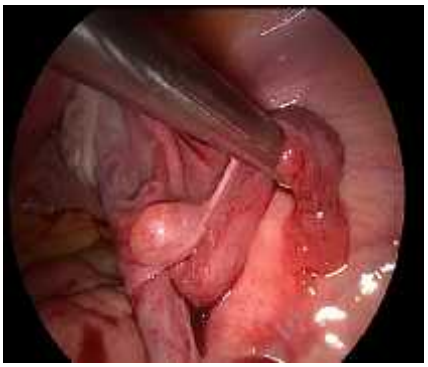
**Corresponding author: SanchitaDubey*
Department of Obstetrics and Gynaecology Apollo Hospital

PUL –Pregnancy of Unkown Location

41 Years G5 P2L2A2 came with complain of pain abdomen one week back
UPT -Positive
18/7/16 USG - uterus shows no evidence of gestation sac and adnexa normal. Left ovarian anechoic cyst measures 10mm.ET-11mm
B-HCG-1230miu/l
20/7REPEAT USG- no gestational sac .left sided cystic lesion - 9.6mm with peripheral blood flow and probe tenderness+ ,no free fluid –left sided ectopic gestation +,left ovarian cyst measures 23mm, right adnexa normal.ET:16.2mm.
OBSTETRIC H/O: Both normal delivery and two MTP in first trimester
PLAN: Patient also wanted family planning operation we proceeded to surgical management Laparoscopic right salpingectomy with left laparoscopic tubal ligation with D&C
FINDING:.(Shown in fig-2)



LEFT TUBE



RIGHT TUBE

Figure-2

- Corpus luteum present on left ovary
- Left tube and ovary normal
- Right tubal fresh bleed was seen trickling from fimbrial end which was suggestive of right tubal ectopic thus– right sided salpingectomy performed and sent for HPE
- since we were not confident about ectopic location we gave inj methotrexate after procedure
- D&C done

HPE report did not confirmed tubal ectopic pregnancy.
Follow up B-HCG was done till it was negative

CASE-3: Surgical Management of Ectopic

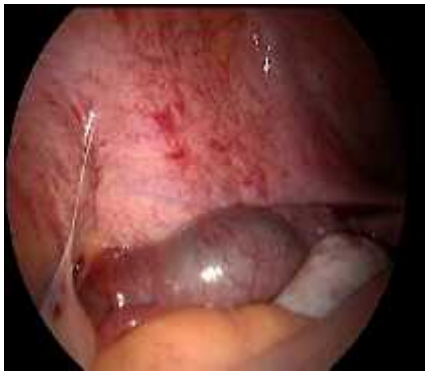
40 Years G3P2L3 at 6weeks and 3days came with amenorrhea of more than one month (LMP-1/6/16)
8/7 UPT-Negative on examination

P/A: Mild tenderness was present over right iliac fossa

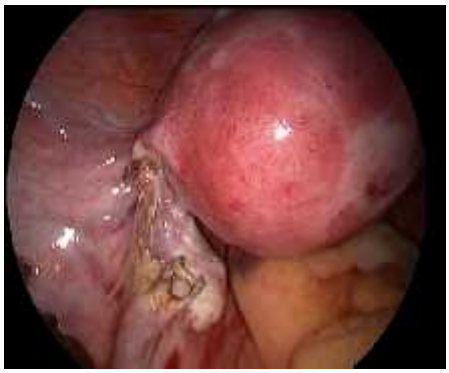
14/7 B-HCG-7754miu/l
15/7USG- Right ectopic pregnancy, ET-15.3mm. No intrauterine sac seen.
OBSTETRIC H/O:2 Previous LSCS, LCB-2years
PLAN: In view of completed family Laparoscopy was planned but due to omental adhesions proceeded to Laparotomy.

Finding

- Right tubal ectopic mass of 3x3cm seen, salpingectomy done
- Hemoperitoneum+
- Left tubal ligation done.
- Left fimbrial cyst 2x2cm aspirated.
- D&C done



LEFT TUBE



RIGHT TUBE

Figure-3

Case -4 Heterotopic Pregnancy

35Years G3P2L2 at 8weeks and 3days she came with complain of spotting P/V since one week without any proper flow (11/7).
LMP-6/7/16
Patient had a h/o of intake of I- pill 3weeks back
She donot have any complain of pain.

On examination: there was acute tenderness on left iliac fossa

In view of tenderness (11/7) USG done which showed- missed abortion with intrauterine sac of 8weeks and 4days MSD-3.4cm

11/7B-HCG-2606miu/l

Dilatation of left tube was to be confirmed by TVS to rule out ectopic but patient refused and we did not insist since IUP was obvious

OBSTRETIC H/O- Both normal vaginal delivery.
PLAN- in view of missed abortion and completed family patient opted for D&C and tubal ligation. Patient wanted to delay procedure due to personnel reasons for 2-3 days but due to pain abdomen next day she got admitted and agreed for above procedure.

FINDINGS: (shown in fig -3)
Heamoperitoneum of about 50-100ml with clots was noted with left tubal ectopic pregnancy and thus proceeded to Laparoscopic left salpingectomy with right tubal ligation and D&C.

Case-5 Surgical Management of Ectopic

34 Years G2A1 at 7weeks and 2days with h/o pain abdomen since morning and unable to pass urine.

Previously patient had shown in local hospital one week back were B-HCG was done and was found to be 1213miu/l and Patient was treated with susten and inj HCG was given but USG was not done.

USG was done on admission to our hospital and showed no intrauterine pregnancy and no signs of ectopic pregnancy but B-HCG was done found to be 13,906miu/l.
And repeat B-HCG after 48 hrs was 25,631miu/l
thus USG was repeated.

1/8 USG-Right ruptured adnexal ectopic pregnancy with free fluid in POD 11.4ml.
MENSTRUAL H/O: Patient also gives history of irregular menstrual cycles but since 6months cycles were told to be regular. OBESTRETICS H/O: Previously MTP was done due encephalous baby.
PLAN:
Laparoscopic right salpingectomy with D&C
FINDINGS: (shown in fig -4)

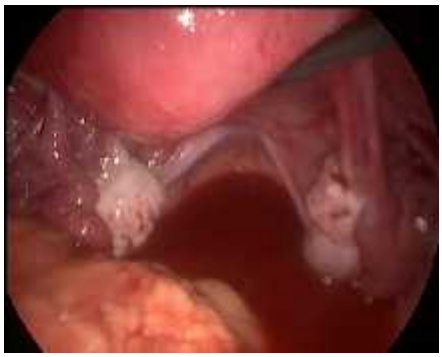
RIGHT SIDED TUBE

Figure-4

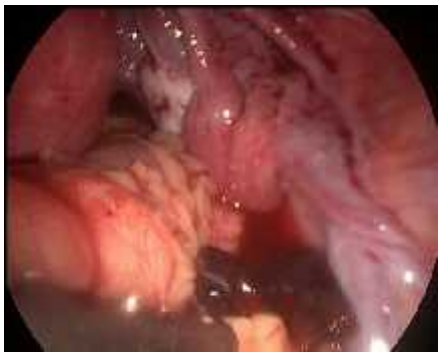
- Massive heamoperitoneum with clots measuring 1000cc
- Right sided isthmic rupture with active bleeding visualised
- Left sided tube beaded in appearance
- B/L ovaries normal
- D&C done

Case -6 Medical Management of Ectopic Pregnancy
30 Years G2P1L1A2 at 4weeks and 4days admitted with Spotting P/V and pain lower abdomen since 1hr prior to admission.
LMP-10/6/16
Patient took i-pill on 20/6/16
11/7UPT-Positive
11/7B-HCG-1190miu/l
USG –showed a right adnexal mass of 3x2.8cm with grade 1 Peripheral vascularity, ET-12mm.
OBSTETRICS H/O-LSCS 2years back and
A1-Medical MTP
A2-D&C
Medical management was chosen and inj. Methotrexate 50mg im was given.

Patient had episode of pain abdomen after that which increased in intensity and B-HCG was repeated showed doubling of titers and patient was taken for laparoscopy. FINDINGS:(shown in fig-5)



HEAMOPERITONEUM



RIGHT TUBAL ABORTION

Figure-5

- Heamoperitoneum of 5-10cc noted
- Right side tubal abortion noted ,blood clots seen attached to fimbrial end of right tube
- Right tube appeared normal in morphology with no bleeders thus was left in situ
- Left side tube appear normal
- B/L ovaries normal

Injection Methotrexate given after procedure

Case -7 Chronic Ectopic Gestation

31 Years G3P1L1A1 Previous LSCS and K/C/O of TB(treated in 2012) had continues spotting P/V accompanied with pain abdomen since one and half month

Patient had history of intake of T.Misoprostol for 2days 6hrly after being diagnosed to be pregnant one month back.(LMP-21/4 ;UPT Positive 23/5)

USG repeated after that was told to be normal But since than patient had history of pain abdomen on and off and repeated USG showed no intrauterine or ectopic pregnancy

Finally!!!
USG(4/7) Showed left tubal region with diffuse thick-walled tubular shaped lesion measuring 3.9x3.4x3.1cm possibly -left tubal gestation (chronic stage) with hemoperitoneum 80-100cc.
B-HCG(4/7) -38.83miu/l
Repeat B-HCG (After one day) was 27miu/l(decreasing)
Thus patient was planned for medical management and given Inj Methotrexate i.m

Repeat B-HCG and USG after treatment showed regression of ectopic.

Case-8 Left Corunal Pregnancy

37 years G4P1L1A2 at 9weeks and 5days period of gestation. Patient had spotting P/V since 12 days with heavy bleeding since last 4 days accompanied by mild pain abdomen.
UPT-Positive
B-HCG[1] -30,000miu/l
USG done –showed well defined heterogeneously hypo echoic lesion in fundic myometrium adjacent to left uterine cornua - FIBROID
In view of high B-HCG, investigations repeated again
B-HCG[2] (AFTER 48HRS)-23,330miu/l
USG (REPEATED AGAIN) - showed left corunal pregnancy
OBSTETRIC H/O: Normal vaginal delivery
2 MTP at 45 days of amenorrhea

Patient was planned for medical management since B-HCG level were falling and given inj.Methotrexate 80mg i.m. Repeat B-HCG after 48 hrs was 19000miu/l and in view of high initial B-HCG values inj.Methotrexate repeated again Patient investigations was repeated and results showed trend of regressing ectopic

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