Ovarian Ectopic Pregnancy: A Rare Case Report

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ABSTRACT

Ovarian pregnancy is the most common type of non-tubal ectopic pregnancy. Ovarian ectopic pregnancy incidence after natural conception ranges from 1 in 2000 to 1 in 60,000 deliveries and accounts for 3% of all ectopic pregnancies. Here, we report a rare case of ruptured ectopic pregnancy. A 30 years old, G2P1+0L1 was admitted with amenorrhea of 1½ months and severe pain abdomen. Self urinary pregnancy test (UPT) was positive. Ultrasonography (USG) revealed it sided adnexal mass. Emergency laparotomy was done and a diagnosis of ovarian ectopic pregnancy was made.

Keywords: Extrauterine pregnancy, Ovarian ectopic, Partial ovariectomy.


Source of support: Nil
Conflict of interest: None

INTRODUCTION

Ovarian ectopic pregnancy is a rare variant of ectopic implantation. It ends with rupture before the end of the first trimester. The incidence has increased in the last 50 years with causes attributable to better diagnostic modalities, increased use of intrauterine devices, ovulatory drugs, and assisted reproductive techniques. A history of pelvic inflammatory disease (PID) has been implicated in the increase, as well.

Primary ovarian ectopic pregnancy is a rare type of ectopic pregnancy which has an estimated prevalence ranging from 1:7000 to 1:70,000 accounting for almost 3% of all ectopic cases. It is usually terminated by a rupture in the first trimester and because of the increased vascularization of the ovarian tissue it leads to internal hemorrhage and hypovolemic shock status. The diagnosis is usually made by emergency laparotomies and histopathologic assessment.

Diagnosis is made using the Spiegelberg criteria which include:

- The gestational sac is located in the region of the ovary.
- The ectopic pregnancy is attached to the uterus by the ovarian ligament.
- Ovarian tissue in the wall of the gestational sac is proved histologically.
- The tube on the involved side is intact.

Here, we are presenting a rare case of ruptured ovarian ectopic pregnancy.

CASE REPORT

A 30 years old, G2P1+0L1, was referred to our hospital from Badaun in view of ruptured ectopic pregnancy. She had amenorrhea of 1½ months with complaint of sudden onset of pain in lower abdomen for 2 days and one attack of fainting 2 days back. Self urinary pregnancy test (UPT) was positive at home 5 days back. Her last menstrual period (LMP) was Nov 15, 2015. Her last child birth was 4 years back. Her previous cycles were regular, with 6 to 7 days bleeding in every 28 to 30 days, average flow and no dysmenorrhea. Her first pregnancy was 4 years back, term vaginal delivery at hospital, no intrapartum and postpartum complications. No history of any contraceptive use and there was a history of tuberculosis in husband 1 year back and he was on treatment from Delhi. Patient was conscious and well-oriented, pallor was ++++, pulse was 132 beats/min (irregular) and blood pressure (BP) was 134/80 mm of Hg. On abdominal examination, guarding was +++ and tenderness was + in the lower abdomen. On per vaginum examination, vagina was pale and Culdocentesis was positive. On per vaginum, uterus was anteverted, exact size could not be assessed due to tenderness, cervical motion tenderness was present and tenderness was present in all the fornices. On investigation, urinary pregnancy test (UPT) was positive, hemoglobin (Hb) was 4.8 gm%, total leukocyte count (TLC) was 7000/mm³ and platelet count was 1.32 lac/mm³ and the blood group was A+. An ultrasonography report from outside suggested ruptured ectopic of left side. Provisional diagnosis was ruptured ectopic pregnancy. Exploratory laparotomy followed by partial oophorectomy was done.

Intraoperatively, hemoperitoneum of about 400 cc present, clots of approximately 200 cc were removed, uterus was normal in size and both tubes were found to be normal (Fig. 1). Right-sided ovary was normal and ruptured ovarian ectopic pregnancy was seen on the left side. The ruptured ovarian ectopic and the ovarian
tissue were sent for histopathological examination with a provisional diagnosis of ruptured left-sided ovarian ectopic pregnancy. Her postoperative period was uneventful.

Histopathology shows evidence of chorionic villi along with trophoblastic cells, which gave the impression of ovarian ectopic pregnancy (Fig. 2).

**DISCUSSION**

Primary ovarian pregnancy is one of the rarest type of extrauterine pregnancies. With few exceptions, the initial diagnosis is made on the operating table and the final diagnosis is made only after histopathological examination on the basis of the Spigelberg criteria, establishing that the pregnancy is limited only to the ovaries and does not involve the tubes.

The cause of primary ovarian pregnancy remains obscure. Some theories conclude that it may be due to interference in the release of ovum from ruptured follicle, malfunction of the tubes and the inflammatory thickening of tunica albuginea. Intrauterine contraceptive device use may also be a cause. The signs and symptoms of ovarian pregnancy are similar to tubal pregnancy, it may be confused with ruptured hemorrhagic corpus luteum, or chocolate cyst or tubal ectopic pregnancy. With the improvement in ultrasonographic skills and instrumentation, especially with the help of vaginal probe, ovarian pregnancy can be diagnosed preoperatively.

**CONCLUSION**

Although ovarian ectopic pregnancy is a rare condition, after careful evaluation, the selection of medical procedures should take into consideration the preservation of fertility particularly for young patients.

**REFERENCES**