

Live Healthy Full Term Ovarian Pregnancy

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Abstract

Primary ovarian pregnancy is a rare entity, constituting about 0.5% to 1% of all ectopic pregnancies. We present a case of left ovarian ectopic pregnancy in a 40 years old female, who was admitted at Diabetic Association Medical College Hospital, Faridpur with the complaints of irregular per vaginal bleeding for six months followed by amenorrhea for last five months. She also noticed that increasing abdominal distension and discomfort, increased frequency of micturition. Clinically she was pale with pulse of 90/min and blood pressure of 120/80 mmHg. The abdomen was distended of 36 weeks size and tenderness present. Grips could not be assessed properly. The vaginal examination revealed closed cervix with mildly tender fornixes. The clinical diagnosis of full term pregnancy with abnormal presentation was made. On investigation full term pregnancy with breech presentation by USG were detected. Pre-operative diagnosis of term ovarian ectopic pregnancy still remains a challenge in spite of current medical advances.

Key words: Ovarian Ectopic pregnancy, Full term healthy fetus.

Introduction

Ovarian pregnancy is defined as the implantation of the conceptus on the surface of the ovary or inside the ovary, away from the fallopian tube. The first reported case live full term ovarian pregnancy was reported in the Indian Journal of Obstet and Gynaecol on 1970¹. Ectopic pregnancy is common admitted patient in our hospital. But ovarian pregnancy is the rarest form. Most of them are tubal within the fallopian tube (tubal about 98%). The frequency of ovarian pregnancy is less than a tubal pregnancy and constitutes 0.5-1% of all ectopic pregnancies². These cases present with ruptures with intra abdominal hemorrhage and other consequence.

Ovarian pregnancy may be primary when ovum is fertilized in the peritoneal cavity and then implanted in the ovary. In case of secondary ovarian pregnancy fertilization occurs in the fallopian tube then there is tubal abortion which later on become implanted on the ovary. This condition is difficult to diagnose before surgery³. Transvaginal ultrasound has proved to be an invaluable tool in the diagnosis of ovarian ectopic pregnancy⁴.

Here, we report a patient with an ovarian pregnancy who was diagnosed after laparotomy.

Case report

A 40 years old female patient admitted with a history of 5 months amenorrhea with increasing abdominal distension and discomfort, increased frequency of micturition. She had 5 earlier full term and normal deliveries, the last being 4 years earlier. She used injection for contraception for about one year. She also noticed irregular per vaginal bleeding lasting for 6 months after stopping the injection. Clinically she was pale with pulse of 90/min and blood pressure of 120/80 mmHg. The abdomen was distended of 36 weeks size and tenderness present. Grips could not be assessed properly. The vaginal examination revealed closed cervix with mildly tender fornixes. The clinical diagnosis of full term pregnancy with abnormal presentation was made. On investigation Hb%-45%, blood group A⁺⁺⁺, full term pregnancy with breech presentation by USG were detected. Due to increasing abdominal discomfort emergency LUCS was proceeded with a Pfannenstiel incision. After opening the peritoneum the uterus was found normal looking bulky size and a large cyst arising from the left ovary. The incision was enlarged by midline extension, then the cyst was tried to pull out through that wound. The cyst wall ruptured with a miracle finding of a full term healthy male baby within it. The baby and placenta were completely enclosed within the cyst wall. Ovarian pedicle contained the large vessels supplying the fetus. Then ovarian mass containing the placenta removed ligating at the pedicle.

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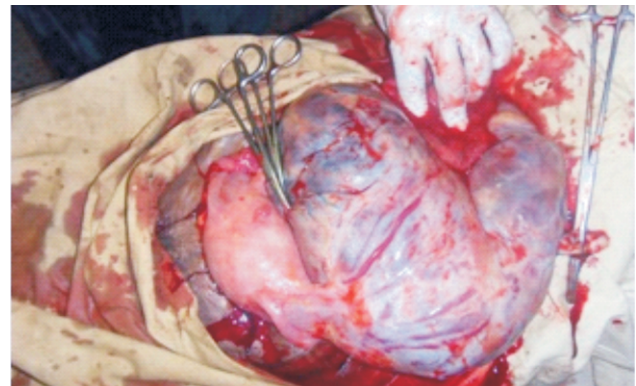


Fig: Ovarian Pregnancy.

Discussion

The conditions most commonly confused with ectopic ovarian pregnancy, both clinically and pathologically are ruptured hemorrhagic corpora lutea, "chocolate" cysts and ruptured tubal ectopic pregnancies. Therefore, the Spiegelberg criteria⁵ are important to diagnose ovarian pregnancy. All these criteria were fulfilled by the case presented here. Both tubal and ovarian pregnancies are believed to occur more frequently in the users of intrauterine contraceptive devices. Though the uterine implantation of the fertilized ovum is sharply reduced by the use of such device, there is no protection against pregnancies occurring elsewhere. The patients presented here had not used IUCD. However, among 22 patients presented in Indian literature, two had used IUCD^{6,7}. Review of the Indian literature shows no definite age group⁸, the range being between 21 and 43 years in the 22 reported cases of primary ectopic ovarian pregnancy. The mean parity of 3 was observed with only two ovarian pregnancies, occurring at first time and four at second time^{9,11}. No predilection to any side was seen. The period of amenorrhea varied from none to 14 months^{12,13}. In the two instances, the pregnancy continued to full term with one healthy newborn being delivered^{14,15}. No definite relationship as regards the interval from an earlier pregnancy was observed. It is, therefore, obvious that primary ectopic ovarian pregnancy is probably a random and a chance occurrence. Out of the modern methods, ultrasonography, laparoscopy and estimation of human chorionic gonadotrophic (HCG) levels have been used in conjunction with repeated clinical evaluation in the diagnosis and management of extra uterine pregnancies^{16,17}.

Bradley et al¹⁸ reported the 'classic' findings which differentiated the double ring of the decidua parietalis and capsularis of an intrauterine, pregnancy-gestational-sac from that of a single ring of the pseudo gestational sac of an ectopic pregnancy. Subsequent studies suggested that these 'classic' findings were not specific for ectopic pregnancy as they were often proved surgically to be tuba-ovarian or appendicular abscesses¹⁹. It became clear that actual definitive demonstration of extra uterine gestational sac was rare and neither specific nor sensitive enough to be relied on to diagnose this life threatening process^{20,21}. The HCG levels of over 6500 m IU/ml with ultrasonographic suggestion of presence of a gestational sac indicates continuing intrauterine pregnancy since the coexistence of an intrauterine pregnancy and an ectopic pregnancy is very rare, the current approach of many sonographers is to virtually exclude an ectopic pregnancy by demonstrating an intra-uterine, pregnancy. Therefore, if the patient is acutely ill, laparoscopy may be the procedure of choice. If the patient's condition is stable, the clinician may choose to observe the patient, follow serial quantitative HCG levels and obtain a follow-up sonogram to sac if definitive signs of an intrauterine pregnancy appear²²⁻²⁴.

Conclusion

Ovarian ectopic pregnancy is a very rare condition not only difficult to diagnose but also to distinguish from tubal

ectopic pregnancy. Management is essentially surgical and early diagnosis and intervention can prevent mortality.

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