RUPTURED OVARIAN PREGNANCY - A RARE CASE REPORT

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Abstract

Ovarian pregnancy is an uncommon presentation of ectopic gestation and usually, it ends with rupture before the end of the first trimester. Its presentation often is difficult to distinguish from that of tubal ectopic pregnancy and hemorrhagic ovarian cyst. Hereby, presenting a case of primary ovarian pregnancy in a 23-year-old patient, referred from private hospital as ectopic to govt. RSRM hospital, Stanley medical college. She presented with the complaint of severe lower abdominal pain and c/o spotting per vaginum from the previous day. Patient was diagnosed to have right adnexal mass measuring 3x2cm and the uterine cavity was found empty by transabdominal sonography. Free fluid was found in the Douglas pouch diagnosed as ectopic tubal pregnancy. Henceforth, proceeded with emergency laparotomy and found intraoperatively that patient showing intact tube with ruptured ovarian pregnancy, hence proceeded with right salpingo ovariotomy with left tubectomy. Aetiological, clinical and therapeutical aspects of this rare extrauterine pregnancy are described. Also, the problems of its differential diagnosis are discussed.

KEYWORDS: Rupture, ovarian pregnancy, laparotomy, ultrasonography

INTRODUCTION:

Ovarian pregnancy is a rare type of extrauterine pregnancy. Primary ovarian pregnancy is a rare entity, the diagnosis of which continues to challenge the practising clinicians. In contrast to tubal pregnancy, ovarian pregnancy occurs as a single event in an otherwise healthy women. There is no specific clinical, laboratory test or ultrasonography signs for differentiating ovarian from tubal pregnancy. Laparoscopy frequently shows haemorrhage from the corpus luteum or a rupture of ovarian cyst. Histology is the only means of establishing the diagnosis. Ovarian pregnancy is often more dangerous than tubal pregnancy, but conservative treatment is often possible.

Here we report a rare case of ruptured ovarian pregnancy whose tissue samples sent to the (pathology) department confirms the presence of products of conception with normal tubal morphology.

Case report:

25 year old female with G2P2L2A0 was referred from private hospital as ectopic pregnancy to govt. RSRM hospital. she had complaints of lower abdominal pain and spotting per vaginum from one day before. on examination she was anaemic, acyanosed, afebrile. HR 78/min; PR 82/minute; BP :110/80mmHG; CVS: S1S2 heard; RS: normal vesicular breath sounds heard; P/A-soft; P/V-cervix -normal; uterus -anteverted; right sided fornical fullness positive.

Figure 1: Intra Operative Picture Showing The Ruptured Ovarian Pregnancy With Normal Fallopian Tubes.

Figure 2: Gross Pathology Showing Ovarian Parenchyma With Haemorrhagic Soft Tissue.
Right adnexal mass measuring 3x2 cm; with uterine cavity empty and presence of free fluid in the pouch of douglas was found by ultrasonography.

Hence, she was diagnosed as ruptured tubal pregnancy and proceeded to emergency laparotomy. Intraoperatively she presented with hemoperitoneum with clots. Both the tubes found to be normal. Left ovary normal and right ovary found ruptured possessing products of conception and hence diagnosed as ruptured ectopic ovarian pregnancy.

Then proceeded with emergency laparotomy with right salpingo ovariectomy with left tubectomy. The tissue sent to pathology department showed products of conception and normal tubal morphology.

**DISCUSSION:**

Ovarian pregnancies are rare. The vast majority of ectopic pregnancies occur in the fallopian tube; only about 0.15-3% of ectopics occur in the ovary (1). The incidence has been reported to be about 1:3,000 to 1:7,000 deliveries.(2)

Ovarian pregnancy is a rare variant of ectopic pregnancy. The etiology of ovarian pregnancy is unknown, specifically as the usual causative factors – pelvic inflammatory disease and pelvic surgery – implicated in tubal ectopic pregnancy seem to be uninvolved. It cannot be concluded that intrauterine device increases the risk for ectopic ovarian pregnancy, whereas invitro fertilisation (IVF) has increased for ovarian pregnancy.

Early diagnosis of ovarian pregnancy is necessary in order to avoid more serious complications and emergency invasive procedures. However, preoperative diagnosis remains challenging, and it is diagnosed generally during surgery(3). Correct diagnosis of ectopic pregnancy can often be made on the basis of patient history, signs and symptoms, serum beta-hCG levels, and pelvic US examination.

In our case, ultrasound examination has diagnosed as tubal pregnancy whereas intraoperatively the diagnosis of ovarian pregnancy was made. An accurate differential diagnosis is important in ectopic pregnancies as patient management often differs depending on the type and the exact location of the pregnancy. Medical therapy with methotrexate was not a possible option due to the occurrence of massive bleeding. As Few cases of laparoscopic treatment in women with hemoperitoneum have been reported. In our case the ovarian pregnancy was removed with right salpingo oophorectomy with left tubectomy by emergency laparotomy.(4)

**CONCLUSION:**

Diagnosing an ovarian pregnancy is difficult. Primary ovarian pregnancy may occur without the presence of any classical risk factors for ectopic pregnancy. So with features suggestive of tubal ectopic pregnancy and intraoperative finding of normal tubes should alert the obstetrician to suspect ovarian pregnancy.(5) Early diagnosis and prompt treatment can allow for conservative surgery and future fertility of the patient.

**REFERENCES:**