CASE OF TUBAL PREGNANCY OCCURRING IN THE STUMP OF TUBE AFTER OVARIOTOMY

by

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Pt. K., aged 25 years, was admitted to the S. S. Hospital on 20-7-63 at 10 A.M. with a history of abdominal pain and vaginal bleeding since 15 days.

Present complaint:

Patient had an ovariotomy done about the middle of January 1963.

At operation an ovarian cyst about the size of a cocoanut was seen arising from the right ovary. Since all the ovarian tissue was involved the pedicle was double clamped and double ligatured with double strands of black silk and an ovariotomy was performed by Dr. Tiwari. According to her only about ¾" of tube was left. The stump of the tube was double ligatured along with the rest of the pedicle with black silk. She menstruated normally for 4 months after the operation. The last period started in the last week of May. She missed her period in June and 15 days later experienced sudden severe pain on the right side of the lower abdomen, after which she started vaginal bleeding. A lump also appeared in the lower abdomen at the same time and gradually attained the present size, which is about the size of a 22 weeks' pregnant uterus.

O.H.: Three deliveries full-term and usual. First 2 alive, boys; Last delivery 8 years back—boy—died after 15 days. 1 abortion at the 5th month 1 year back.

Menstrual History: 4-7/30 days, normal; each menstrual period end of May '63. (Had poly-menorrhoea for 6 months prior to ovariotomy.)

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General examination: Fairly well-built, anaemic, Pulse 94/mt.-T.-98.4°F., Haemoglobin—8.5 gms., Blood pressure—110/70.

Systemic examination: All systems normal.

Per abdomen: Healthy healed scar of previous abdominal operation seen in the left lower paramedian position. A lump visualised in the lower abdomen arising from the suprapubic region and reaching up to an inch below the umbilicus; it appeared to arise from the pelvis, the size being of about 22 weeks' pregnancy, tender, not mobile and of variable consistency.

Per vaginam—Cervix was pushed against the symphysis pubis, uterus was felt to be anteverted and slightly bulky. A mass was felt ballooning out the posterior fornix and extending up to 1" below the umbilicus; it was moderately tender and was firm in places and cystic in others. A diagnosis of pelvic haematocele was made and confirmed by aspirating the Douglas's pouch. An immediate laparotomy was decided upon and saline infusion started.

Under general anaesthesia abdomen was opened by a right paramedian incision at 3 P.M. Free blood was not present in the peritoneal cavity. A big pelvic haematocele was found posterior to the uterus in a sac formed by intestines, both mesosalpinges and the uterus (Fig. 1). Anatomy of the whole pelvis was badly distorted due to adhesions. The haematocele was opened and emptied and the adhesions separated. After this procedure the anatomy of the pelvis could be made out.

Fig. 1. Left ovary and tube were present and looked healthy. Right ovary and the distal part of right tube were absent, thus indicating that the previous ovariotomy was right-sided. About 1½" of right tube was left. The distal part of the stump of the

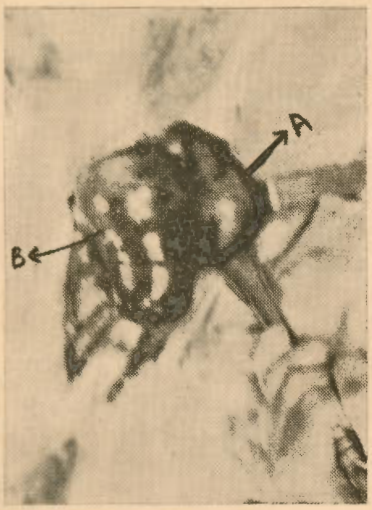

Fig. 1
(a) Uterus, (b) Sac of ruptured ectopic pregnancy.

right tube had become the seat of a tubal pregnancy and ruptured. The stump of the right tube was removed completely by a cornual excision, covering the stitched area with the round ligament. A fairly good amount of degenerated placental tissue along with an abundance of blood clots and fluid blood was removed from the haematocele but the embryo could not be distinguished. There was a lot of oozing from the denuded areas. As much of the area as possible was peritonised, rubber drains were put into Douglas's pouch, and the peritoneal cavity and the abdomen closed in layers. Blood transfusion was started as soon as the ruptured stump of the right tube was clamped.

The rubber drains were removed after 48 hours since the amount of blood oozing from the drains was negligible after the first 12 hours. Post-operative period was uneventful except for a moderate degree of pelvic cellulitis which cleared with antibiotics and pelvic diathermy. Patient was discharged well on 23-8-63.

Remarks

This seems to be a true case of internal migration of the fertilised

Fig. 2
(a) Ruptured stump of right tube, (b) Uterus, (c) Sac of ruptured ectopic pregnancy, (d) left ovary.

ovum. Since only the left ovary was present, the ovum discharged from the left ovary must have entered the left tube and after fertilization travelled across the uterine cavity to the closed stump of the right tube left after the previous ovariotomy. An external migration could not have been possible since the pedicle of the removed right ovarian cyst containing the stump of the right tube must have been ligated and closed. (The information that an ovariotomy was done in January 63 was collected from a discharge slip which was with the patient. The details of the operation were not available). This case illustrates the importance of doing a complete cornual excision when doing a salpingectomy. I wish to express my gratitude to the Principal, College of Medical Sciences, Banaras Hindu University for allowing me to publish this case.

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