ECTOPIC PREGNANCY WITH LIPPES LOOP

Report of two cases

by

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Various complications have been reported with the insertion of I.U.C.D. but major complications like perforation of uterus or ectopic gastation with loop in situ, are not of common occurrence. These two cases of ectopic pregnancy with loop in situ are reported here because (1) it is a rare complication and (2) it is a dangerous complication and may prove fatal if not diagnosed.

CASE REPORT

Case 1

Mrs. X. Y. Z., Hindu female, age 27 years, was admitted at the Mayo General Hospital on 21-7-68 at 2.30 P.M. as an emergency. She had a Lippes loop inserted 2 years ago during lactational amenorrhoea, i.e. four months after her delivery. The loop was removed at a primary health centre 15 days prior to her admission as she was complaining of pain in the abdomen for one month and slight bleeding per vaginam for 15 days. The pain was in the left iliac fossa. After removal of the loop she had vomiting and fainting attacks for two days. She was shifted to the hospital 7 days after removal of the loop.

The general condition of the patient was satisfactory. The cardiovascular system was normal. Vaginal examination showed the uterus to be of normal size; a boggy tender mass was felt in the left fornix. Brownish discharge was present per vaginam.

Investigations: Urine showed a few pus cells. Blood group — 'B'. Screening chest-normal. Total leucocytic count-8,200 per cmm; differential count; poly 50%; lympho 48%; eo 2%, Hb 50%; E.S.R. 60 mm. A diagnosis of pelvic infection was made and she was given Terramycin for 7 days with no relief. Repeat vaginal examination after 7 days revealed a definite tender mass in the left fornix. The diagnosis was now changed to ectopic pregnancy, though she had the loop in till 15 days ago.

She had no history of amenorrhoea and had 7 full term normal deliveries, and two abortions in between. Her last delivery was two years ago.

The patient was subjected to a laparotomy on 3-8-68 under spinal anaesthesia, through a subumbilical midline incision. The left tube was distended near the fimbrial end and there was a left tubal abortion. Left salpingectomy was done. The right tube and right ovary were normal and free from any previous infection. The abdomen was closed in layers and patient was discharged on 19-8-68.

Case 2

Mrs. X.Y.Z., a Bohra patient, aged 24 years, was admitted at the Muir Memorial Hospital on 25-12-66 with the complaint of pain in the abdomen since the morning. The pain was dragging in nature. The patient had a similar attack of pain in 1961. This time she had no nausea or vomiting or fever but had constipation. She had two full term normal deliveries, both children alive and well. Last menstruation was 4 days.

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There was pain and tenderness in the right iliac fossa. A loop was in position. There was no history of amenorrhoea and as she was a parous woman the case was diagnosed as acute appendicitis and she was admitted in the surgical ward.

Investigations. HB% II gms%; total leucocytic count 6,800 per cmm; differential leucocytic count: poly, 58%; lympho, 38%; mono, 4%; eo, nil. Under general anaesthesia the abdomen was opened through a Macburny's incision, but as there was blood in the peritoneal cavity the abdomen was closed and re-opened through a right paramedian incision. There was a ruptured tubal pregnancy on the right side and a right salpingectomy was done. The appendix was also removed and the abdomen was closed in layers. The patient was given strepto-penicillin and discharged in a fit condition on 4-1-1967.

Discussion

Conception has occurred in spite of the presence of the loop in the uterus. The incidence of pregnancy with loop varies with various authors. Failure rates quoted by Oppenheimer in 1959 was 2.4 per cent and by Lippes 2.9 per cent, but ectopic gestation with loop is still a rarity. In 99 cases of pregnancy with the loop in situ, reported by Tietz, 14 were ectopics. In 7000 insertions of loops by Lippes, 23 cases conceived and 4 were ectopics. Ramkisson-Chen and Kong Tako reported 6 cases of ectopics with the loop in the uterus; two were acute and four were chronic cases of ectopic gestation. Phillips and Gurcharan Kaur reported one case of ectopic gestation with the loop and Ajinkya and Dhurandhar reported one case. Wilson *et al* reported 3 ectopics with a Margulies spiral. The occurrence of 14 cases of ectopic gestation in 99 cases of pregnancy with loop in situ reported by Tietz indicates that fertilization of the ovum must be taking place in the majority of the cases.

In the majority of the cases of ectopic gestation without a loop, there is usually a long history of sterility, but in both the cases presented here such a history was not available. If we think that fertilization of the ovum does take place even in the presence of a loop and if the tubal factor for causing ectopic gestation is absent, can an I.U.C.D. cause a mechanical blockage of the tube and predispose to ectopic gestation?

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