SIMULTANEOUS BILATERAL TUBAL PREGNANCY

(A Case Report)

by

ROSHAN LAL WAKHALOO,* M.B.B.S. (Hons.), D.G.O., M.D.

Ectopic pregnancy is not unusual and recurrence of ectopic pregnancy in the same patient is not rare. Many cases of combined (intra-and extra-uterine) pregnancy have been reported, but the occurrence of simultaneous bilateral tubal pregnancy is rather uncommon. A case is reported here because search of the available literature failed to produce a recorded case of simultaneous bilateral tubal pregnancy. Jeffcoate (1962) mentions under the sites of ectopic pregnancy; "rare possibilities involving twin pregnancy are simultaneous intra-uterine and extra-uterine pregnancy, and simultaneous bilateral tubal pregnancy."

Many papers were presented on the various aspects of extra uterine pregnancy at the 14th All India Obstetric and Gynaecological Congress held at Nagpur in November, 1967. Combining all these reports about 2000 cases of extra-uterine pregnancy were reviewed. None of the authors mentioned simultaneous bilateral tubal pregnancy and keeping in mind the incidence of ectopic gestation as 1 in 300, the occurrence of such a phenomenon appears to be a rarity.

*Lecturer in Obstetrics & Gynaecology, College of Medical Sciences, Banaras Hindu University, Varanasi 5.

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Case Report

Mrs. B., 17 years old, married 6 years, gravida 0, Para 0, was admitted to the surgical service of the hospital attached to College of Medical Sciences, Banaras Hindu University, on the 19th December, 1968, with the complaint of generalised weakness and loss of appetite for 1 year, pain in the abdomen and irregular vaginal bleeding of 1 month's duration.

Since one year she has been growing weak and anorexic. One month back she suddenly had generalised abdominal pain which was severe in intensity and not accompanied by any fever or vomiting. She had not fainted. A local practitioner gave her some injections and the pain decreased in intensity but did not subside. It continued as a dull ache in the lower abdomen, specially on the right side, with acute exacerbations. She was more or less confined to bed. About three days later she started having irregular vaginal bleeding, moderate in amount. She was constipated and had some difficulty in passing urine, but there was no burning of micturition.

She gave a history of fever off and on, with cough and expectoration, but no history of haemoptysis. There was a history of pulmonary tuberculosis in her family. Her menstrual cycles were regular. On admission she was having irregular bleeding for one month following amenorrhoea of four weeks duration. On examination the patient looked obviously ill; she was pale; there was no cyanosis or jaundice. The cervical as well as axillary lymph nodes were enlarged with occasional matting, but not tender. Pulse was 100 per minute, regular and of good volume. Blood pressure was 110/70 mm. Hg. Temp. 99°F. Abdominal examination revealed mild distention of abdomen. Liver was enlarged to

3 cms. below the costal margin, soft and tender. There was no rigidity or guarding of the abdominal wall. In the lower abdomen there was a soft ill-defined mass coming out of the pelvis and rising to about 6 cms. above the symphysis pubis, extending more towards the right iliac fossa. The mass was tender and not mobile. Free fluid could not be demonstrated in the peritoneal cavity. Renal angles were not tender.

With this history and the clinical findings she was diagnosed as a case of abdominal (? ileocaecal) tuberculosis.

Investigations: Haemoglobin 9.2 G%, E.S.R. 61 mm. 1st hour. (Wintrobe); total leucocyte count, 12,800/cmm. Differential, poly 81%, lympo 17%, eosino 2%. Urine NAD Blood urea: 27 mg%, serum electrolytes within normal limits. Screening chest: NAD.

Next morning she was referred to the gynaecological service for consultation. The above findings were confirmed. Vagina healthy, uterus was normal in size, pushed to the left by an ill-defined soft mass occupying the right and posterior fornices. The mass was adherent to the uterus, about the size of a grape fruit, tender and not mobile. Movement of the cervix caused intense pain. The cervix felt soft and looked bluish. A clinical diagnosis of ? ectopic pregnancy,? tubo-ovarian mass was made and it was decided to examine the patient under anesthesia.

Operation notes: examination under general anaesthesia confirmed the above findings. Culdocentesis revealed old blood and confirmed the diagnosis of disturbed ectopic gestation. The abdomen was opened by a midline subumbilical incision. There was some old blood in the peritoneal cavity. The pelvis was full of adhesions involving the omentum, small intestines and the sigmoid colon, and plenty of old blood clots. The adhesions were separated and the uterus with its adnexae identified. The uterus was normal in size, the right Fallopian tube was distended with and surrounded by blood clots, forming an elongated mass, about 10 cms x 6 cm. The ovary was incorporated in the mass. On removing the clots a ragged opening, about 3 cms. x 2 cms., was found on the intraperitoneal surface of the tube and through it blood clots could be seen within the tubal lumen. The left tube was distended in its ampullary and infundibular portions to about 4 cms x 4 cms. with a peritubal haematocoele. The ovary was separate from the mass. This tube was lying above and behind the uterus, being adherent to it. The pouch of Douglas was full of blood clots.

In view of the age and nulliparity of the patient it was thought best to attempt conservative surgery. On the right side such an attempt was out of the question because of the ragged and friable walls of the ruptured site, in the isthmic region of the tube. The ovary was isolated and right sided salpingectomy done. The left tube was the site of a tubal mole involving mostly the ampullary region. Attempt at milking out the products of conception failed. A linear cut was made over the bulge and the products evacuated. The tubal wall was thin and friable which did not take stitches and started bleeding. Excision of this tube was also unfortunately inevitable rendering the woman permanently sterile. Both the ovaries and the uterus were preserved.

Abdominal toilet was done and the abdomen was closed in layers. The patient withstood the operation well and had one unit of blood transfusion. She was put on prophylactic antibiotics. Post-operative period was uneventful and she was discharged from the hospital on the tenth day.

The histopathology of the specimens revealed the presence of chorionic villi in both the tubes. There was evidence of tubercular salpingitis in the left tube; the right tube showed features of chronic inflammation. The patient was put on antitubercular therapy as soon as the report became available. Follow up at six weeks revealed the uterus in midposition, mobile, and the fornices were clear. She was asked to continue antitubercular therapy for two years.

Comments

The incidence of ectopic pregnancy in India is roughly 1 in 300 (Upadhyay 1955/56), 1 in 333 (Mitha 1965). Jarvinen and Kinnunen (1957), analysing a follow up on a series of 854 patients who had been operated upon for ectopic preg-

nancy, found the incidence of recurrence as 11 per cent. However, if only the patients who became pregnant are considered and not the whole group, the incidence of recurrence works out to be 25 per cent. The simultaneous presence of intra-and extra-uterine pregnancy (heterotopic) is rare; about 500 cases have been reported in the world literature (Nag 1968). But the occurrence of simultaneous bilateral tubal pregnancy appears to be exceedingly uncommon.

This is a variety of twin pregnancy originating probably from a single coitus and having two separate sites of implantation. Since it has never been shown that uniovular twins can be partitioned and can have two different sites of implantation, it must be assumed that this pregnancy resulted from fertilisation of two different ova. The possible aetiology in this case was tubercular salpingitis, as evidenced by her history and the histopathology. On the right side it ended with an intra-peritoneal rupture, and on the left side in tubal mole, presenting as a 'subacute or chronic' ectopic, causing some initial difficulty in diagnosis. This once again illustrates to our non-gynaecological colleagues the importance of internal examination in all female patients attending the hospital whatever may be the clinical impression of the case.

No doubt the correct diagnosis of tubal gestation can sometimes be one of the most difficult and perplexing problems in gynaecological practice but the diagnosis of simultaneous bilateral tubal pregnancy will only be made at laparotomy. Such a case demonstrates the importance of examining the adnexae on both sides at laparotomy before deciding on the extent of surgery in ectopics. This case deserved conservative surgery on her tubes, in spite of the various complications of such surgery, but unfortunately we could not do much for her, although in view of the aetiology the odds were against her in having a viable pregnancy.

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