BILATERAL TUBAL GESTATION

by

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The incidence of tubal gestation is increasing in recent times. According to Crawford and Hutchinson (1954) it is one per cent. Occurrence of bilateral tubal pregnancy is extremely rare. A case of ectopic pregnancy in both the fallopian tubes is reported here.

CASE REPORT

Mrs. B. D., aged 30 years, widow (Husband died 15 days back) attended the obstetrical emergency on 1st of March, 1976 at 1 P.M. with the complaint of severe pain in the lower abdomen since 24 hours. She had mild pain in the abdomen for the last 15 days. The pain was so acute for the last 24 hours that she was unable to pass urine and flatus. Her previous menstrual cycles were normal. She had her last menstruation on 3rd Janrary 1976 and again very scanty flow on 6th February, 1976. Since then the scanty, dark coloured vaginal bleeding continued. She had no living child. The first pregnancy was in the left fallopian tube for which laparotomy was done 12 years back. The operation notes were not available to know the exact type of surgery done then. The second pregnancy ended in an abortion at 24th week, 5 years back.

On examination she was found to be in agony, the pulse was 100/minute, blood pressure was 120/70 mm of Hg, cardiovascular and respiratory systems were normal. On abdominal examination the subumbilical median incision was found to be healthy. There was a vague lump situated in the left iliac fossa, soft in consistency, extremely tender.

Vaginal examination revealed marked excitation pain. The pouch of Douglas was full. Exact size of uterus could not be made out due to tenderness. Provisional diagnosis of ectopic gestation was made. She was sedated with Pethedine hydrochloride 100 mg IM and was kept under observation. The blood picture revealed anaemia with no other abnormality. At 6.30 P.M. re-assessment was done. The abdominal lump increased in size which extended up to the umbilicus. There was marked tachycardia.

Immediate laparotomy was done with a pint of blood being transfused. Omental adhesions were separated and haemostasis was secured. The whole peritoneal cavity was full of big blood clots and some amount of fresh blood too. On the right side there was an ectopic gestation sac, size of an egg, which was unruptured. Surprisingly the left tube was also found to have an ectopic gestation sac, ruptured, oozing out lot of blood into the peritoneal cavity. There were flimsy adhesions between left tube, ovary and omentum which signifies probable duration of rupture. This sac was situated very close to the ovary of the ipsilateral side, so much so that suspicion about ovarian pregnancy arose. The right sided gestation sac was in the ampullary region. Bilateral total salpingectomy with ovariotomy of the left side was done. The right ovary was conserved and the raw stumps were peritonized. On naked eye examination of the tubes, it looked like gestation product on both the sides. Both tubes in toto were sent for histological examination and the diagnosis of bilateral tubal pregnancy was confirmed. She had pyrexia and stitch infection in the post-operative period. She was discharged on the 15th day of operation.

Discussion

Bilateral tubal pregnancy is a Gynaecological rarity. It is absolutely impossible to diagnose it clinically without the help of a laparoscope. It becomes difficult to conserve the tubes for future

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function in many cases. In the present case since she was a widow and not anxious for remarriage, bilateral salpingectomy was done.

Unless it is a case of bilateral ruptured tubal pregnancy even on laparotomy it is not always possible to diagnose bilateral tubal pregnancy. The other possibilities are tubal pregnancy of one side with reactionary haematosalpynx of the contralateral side, tubal pregnancy of one side and ovarian pregnancy of the contralateral side. Therefore, the final diagnosis always is done by histology as in our case. Spiegelberg's criteria certainly help to diagnose ovarian pregnancy but this also has a strong point in favour of histology.

In view of her past history it seems that no portion of the tube was grossly damaged and removed for ectopic pregnancy 12 years back. Most probably simply the products must had been milked out. Possibly the tubal pregnancies took place in 2 consecutive cycles. The ruptured gestation sac (Left side) seemed to be older than the unruptured one.

In a case reported by Patel *et al* (1977) there was bilateral ruptured tubal pregnancy, the right sided ectopic had formed a secondary abdominal pregnancy with mummification of the foetus and the left sided ectopic was in a stage of fresh rupture.

Summary

A case of bilateral tubal pregnancy with ruptured sac of one side is reported. It is of interest due to its extreme rarity. The diagnosis is done either by laparoscopy or at the time of laparotomy. In the present case diagnosis was done during laparotomy.

References

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