POST TUBECTOMY TUBAL PREGNANCY RUPTURE

(A Case Report)

by

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Diagnosis of tubal pregnancy is some times delayed because of the previous history of sterilisation. It is paradoxical that the diagnosis of an intrauterine pregnancy after tubal sterilisation is rarely in doubt, yet the possibility of the fertilised ovum implanting in a tube is sometimes over looked.

The frequency of ectopic pregnancy in the failed sterilisation cases recorded in a period of 3 years in one unit is 1 in 10. Except this case who underwent vacuum aspiration and tubectomy in this Hospital, all others were operated elsewhere.

CASE REPORT

L.B. 35 years was admitted on 10-9-1977. With sudden attack of lower abdominal pain and vomiting of one hour duration. Vacuum aspiration and an abdominal tubectomy by modified Pomroy's technique was done on 11-5-1976. Since then she was menstruating every month, though blood loss was excessive. Her last period was 15 days prior to the time of admission and she was still bleeding.

She had 6 full term home deliveries.

On examination she was found to be anaemic, pulse was 100 per minute, B.P. 90/60 mm. Hg. Tenderness and a vague fullness in the suprapubic region were noticed. On vaginal examination, uterus was found to be retroverted and normal in size. Right fornix was tender, but there was no mass.

After she was being shifted from the outpatient to the ward she felt giddy, vomited and became pale. She was in profound shock with a rapid pulse and hypotension. Rupture of tubal pregnancy and severe internal haemorrhage was thought off. Laparotomy was done under general anaesthesia. There was fresh liquid and clotted blood about one litre in quantity. Right fallopian tube at the tubectomy site towards the fimbrial end was found to have ruptured through which a blood clot was seen protruding. Right salpingectomy was done. One bottle of 'A' group blood was transfused. Postoperative recovery was uneventful.

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Discussion

Possible modes of development of tubal pregnancy are, (1) implantation taking place shortly before tubal ligation. (2) Fertilized ovum is hindered to implant in the uterine cavity by the tubectomy operation done just at or before fertilisation (Rao, 1978). (3) Recanalisation with the production of a narrow lumen, sufficient to allow the passage of spermatozea but not the fertilised ovum. (4) Formation of tubo-peritoneal fistula. The passage of the ovum into the tube is permitted where it gets fertilised but its entry into the uterus is prevented by the tubal kinking due to adhesidns. (Simpson *et al* 1961). Tubectomy appears to be an important predisposing factor for development of ectopic pregnancy as one third of all subsequent pregnancies following sterilisations are ectopic (Chakravarthi *et al* 1975).

Abdominal pain and tenderness in the abdomen and pelvis are the constant features (Chakravarthi *et al* 1975).

In 50 per cent of cases there was more than 12 hours delay in treatment, due to incorrect diagnosis, which was mainly due to knowledge of prior sterilisation. Hence diagnosis of ectopic should seriously be considered in post tubectomy cases with acute abdominal pain. In the case reported here the diagnosis of appendicitis was entertained but excluded immediately as she showed signs of shock after being shifted to the ward.

Summary

Case of post tubectomy tubal pregnancy with rupture and internal haemorrhage is reported because of its rarity. Recanalisation with the production of narrow lumen is a possibility here.

Acknowledgement

I thank the patient who reported with this complication and gave me the opportunity to tackle the problem in time.

References

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