RUPTURED ECTOPIC PRIMARY OVARIAN PREGNANCY

by

KASTURI LAL,* M.S., D.G.O., F.I.C.S.
(MRS.) K. MANHAS,** M.D.
and
SANTOSH KHAJURIA,*** M.D.

The incidence of this entity varies from 0.5 per cent to 1.5 per cent of all ectopic pregnancies (Jones, 1969; Reid and Ressvant, 1963). Hertig (1951) reported an incidence 1 in 25,000 to 1 in 40,000 pregnancies. About 250 cases have been reported in the literature (Pratt-Thomas *et al*, 1974). Periodic reports have a salutary effect in reminding us that (1) the entity is not as rare as described in the literature and that (2) a few cases remain undiagnosed due to confused anatomy of the pelvic viscera in this entity, and that (3) this entity is seldom diagnosed clinically.

Due to its fascinating presentation and as a challenge to the diagnostic acumen of the clinician present case of ruptured ectopic ovarian pregnancy deserves to be reported.

CASE REPORT

Mrs. S, aged 30 years, G_3P_2, previous menstrual cycles regular was admitted in Gynaecology Unit II of SMGS Hospital Jammu Medical College on 24th of February 1980 for pain in the lower abdomen and vaginal bleeding for last 1 month and history of 14 weeks amenorrhoea. One month prior to present admission the patient had been admitted in the medical ward for 25 days where she was admitted as a case of intestinal obstruction. At the time of discharge from medical ward she was not completely free from the abdominal pain, so she sought Gynaecological opinion.

On examination, the patient was found to be a blind woman with average built and nourishment and moderate pallor. Her BP and temperature were normal. Physical examination of different systems revealed no abnormality. The lower abdomen was slightly rigid. A firm, tender, irregular mass was palpable 5 cm above the symphysis pubis. The lower margin of the mass could not be defined.

Pelvic examination revealed lax vagina and oozing of blood from within the cervical canal. Cervix was soft. The uterus was retroverted and bulky. A mass attached to the uterus was felt in both lateral fornices and anteriorly. The mass was firm in consistency. In the fornix on the right side, a hard bony structure could be felt. Rectal examination confirmed the vaginal findings. The patient was prepared for operation with the provisional diagnosis of ectopic pregnancy or a solid ovarian tumour.

On Laparotomy the peritoneum was found to be adherent to the mass. The peritoneal adhesions were removed and it was observed that omentum, gut and the appendix were adherent to the mass at different places. All these adhesions were removed. The left ovary was replaced by a mass which was 12 x 10 x 8 cm in size and adherent to the front of the uterus. A lithopaedian was seen emerging through a rent in the mass. The placenta and cord were seen lying in the cavity in this mass. The left fallopian tube was traced upto fimbrial end. It was stretched over the mass. The round ligament on the left side was cut and whole mass was

Prof. and Head, Unit II.
**Lecturer.*
***Lecturer.*
Department of Obstetric and Gynaecology, Government Medical College and SMGS Hospital, Jammu (J & K State).
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made free. The right tube and ovary were normal. Total hysterectomy with bilateral salpingo ophorectomy was performed. The patient had an uneventful recovery and was discharged on 14th postoperative day in satisfactory condition.

Histopathological Report:

Microscopic examination of the cervix, uterus, both fallopian tubes and right ovary revealed no pathology. Microscopic examination of the section taken from the tissue stated to be mass, showed presence of ovarian tissue with evidence of ectopic pregnancy including evidence of placental and foetal tissue.

Discussion

1. The fallopian tube including the fimbriated end on the affected side must be intact and must be distinctly separate from the ovary.

2. The gestation sac must occupy the position of the ovary.

3. The gestation sac must be connected to the uterus by the utero ovarian ligament.

4. Unquestionable ovarian tissue must be demonstrated in the wall of the sac.

5. Well defined chorionic villi must be present in the substance.

References

1. Hertig, A. T.: Am. J. Obstet. Gynec. 62: 920, 1951.
2. Jones, D. L.: Fundamentals of Obstet. Gynec. Vol. I, Faber and Faber, London, 1969.
3. Pratt-Thomas, H. R., White, L. and Messer, H. M.: South Med. J. 67: 920, 1974.
4. Reid, D. J. and Ressvant, J.: Obstet. Gynec. 21: 450, 1963.

See Fig. on Art Paper II