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Editorial

ECTOPIC PREGNANCY

Ectopic pregnancy has always been a fascinating gynaecological problem. In recent years new facets in its causation, diagnosis and management has made it still more interesting.

In women having a subumbilical scar, careful inquiry should be made regarding the nature of previous operation. In about 10 to 15 per cent of women who have undergone previous pelvic surgery, a subsequent ectopic pregnancy is likely to occur. Kinking of the tubes following ventral suspension of the uterus is a recognised cause of ectopic pregnancy. Adhesions following even such simple a procedure as appendicectomy may result in a right side ectopic. Whenever conception occurs with IUD in situ, it is much more likely to be an ectopic than intrauterine.

The diagnosis of ruptured ectopic with diffuse intraperitoneal haemorrhage can be confidently made within a couple of hours of onset of sudden abdominal pain by three dependable signs, rising pulse rate, parallel fall of blood pressure and acute tenderness in all the fornices on vaginal examination. Absence of tenderness in the vaginal fornices generally excludes an ectopic as the cause of intraperitoneal haemorrhage. Laparoscopy is a useful procedure in subactute type of ectopic with indefinite clinical features, but the time tested culdocentesis should be done first which reveals the diagnosis in most cases and then laparoscopy performed to demonstrate the reliability of culdocentesis for the benefit of students, majority of whom would in future practice in rural India. Laparoscopy would also diagnose an unruptured ovarian pregnancy by finding an enlarged ovary having a bluish appearance.

Even though clinical features of intraperitoneal haemorrhage in cases having sixteen to twenty weeks amenorrhoea is typical of a ruptured underdeveloped horn of a bicornuate uterus, yet it is not infrequently diagnosed as acute torsion of an ovarian cyst.

As in other abdominal emergencies, the treatment of ectopic is exploration by adequate abdominal incision. Recently, a few reports have appeared advocating vaginal approach, claiming several advantages. But, apart from demonstration

of proficiency in vaginal surgery there are no other tangible advantages of vaginal approach. At a meeting of Royal College of Surgeons of England, some years ago, a senior surgeon aptly remarked that if he had to have an operation for an abdominal emergency, he would choose a surgeon who believed in making an adequate abdominal incision for proper visualisation.

In recent years, conservative management of an unruptured tubal pregnancy as also tubal pregnancy in previously sterilized women present problems.

Conservative surgery for early, unruptured tubal pregnancy should be individualised according to findings at operation. Several procedures are available: (1) expression of tubal abortion at the fimbrial extremity, (2) salpingostomy, (3) resection of interstitial pregnancy with or without implantation of the tube in the uterine cavity, (4) partial salpingectomy. Of these procedures, partial salpingectomy with end to end anastomosis invites ectopic nidation of ovum by stricture at the site of anastomosis. The other procedures are more favourable for a subsequent intrauterine pregnancy. A unique case of four tubal pregnancies in the same woman was reported by Dawson (J. Obstet. Gynaec. Brit. Emp., Volume 42: page 651, 1934).

There is considerable optimism among medical profession and the general public that reversible microsurgical procedures can result in subsequent intrauterine pregnancy in about 60 per cent of cases. Population Reports (Series, C, No: 8, September 1980) rightly points out that only a handful of expert surgeons proficient in microsurgery have acheived about 60 per cent. The results achieved by other gynaecological surgeons would be about 20 per cent. Unsuccessful surgeons rarely report their results. Woman should be carefully screened before undertaking reversible procedure on the basis of age, fertility, health and condition of the fallopian tubes. It should also be remembered that the rates for ectopic pregnancy after reversible procedure are about 10 times higher than normal.

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