SPONTANEOUS RECOVERY OF ECTOPIC PREGNANCY - A PRELIMINARY REPORT

K.K.Das ● Bani Kumar Mitra ● D.K. Bhattacharjee
Konkon Mitra ● Anjan Dasmal

SUMMARY

Surgery is the mainstay treatment of ectopic pregnancy. Early diagnosis before tubal rupture is possible in a good number of cases today and offers us a number of non-conventional therapeutic options including expectant management without resorting to surgery. Once diagnosed early, prognostic status can be fixed and optimum therapeutic options can be identified. In this preliminary study we have tried to select cases for expectant management and note the outcome.

INTRODUCTION

Before the first successful operative treatment of tubal pregnancy reported by Lawson Tait in 1884, patients suffering from ectopic pregnancies (EP) were managed expectantly by observation only, carrying nearly 69% mortality. Afterward, surgery became the mainstay treatment of EP. Over the past few years however, identification of this disorder at its early stage before tubal rupture is possible by using pelvic scan with a high resolution transvaginal probe (TVS) and detection of circulatory hCG hormone (Das et al 1993). Early diagnosis of EP with intact tubal gestational sac offers a number of therapeutic options. Such treatments are introduced with an aim to arrest tubal distortion and preserve tubal function and restore fertility.

Infertility & Endoscopy Centre, Bokaro Steel City, Bokaro.
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They include conservative surgery like linear salpingostomy, best performed by laparoscopy, medical treatment with inj. methotrexate by salpingocentesis or by intramuscular route and lastly, expectant management with observations only without resorting to surgical or medical intervention. Once EP is diagnosed, prognostic status can be fixed, so that optimum therapeutic approach can be identified (Das and Mitra 1995). In this report attempts have been made to select cases for expectant management, to see how far we can avoid surgery and note the outcome.

OUR PRESENT STUDY:

Our study included a total of 52 EPs from April 1991 to May 1996. In 16 cases some form of conservative line of treatment was planned. Salpingostomy was done in nine, methotrexate was injected in three, two intratubal, one by intramuscular route (Table I). Six cases were selected for expectant management with close follow up using serial pelvic scan and semiquantitative hormone assessment by different pregnancy tests available in the market (Das et al 1993).

Criteria for expectant management

Patients for expectant management were haemodynamically stable, clinically signs & symptoms did not increase, displayed empty uterus, showing no foetal heart beats, no signs of tubal rupture or active intraperitoneal bleeding and the diameter of the tubal mass would not be more than 4 cm by TVS. The initial B-hCG titer was less than 1000 miu/ml and subsequently displayed a declining hormone level.

Follow up

All patients were followed up every 1-5 days, two were admitted and four were studied as outpatients to have repeat pelvic scan and pregnancy tests. Later the intervals were longer till the Visi-preg / Stat-Pak Card (specific to 25 MIU/ML) became negative within 15 days (range 7-30 days) and the tubal mass reduced in size or disappeared. Mean length of follow up was 21 days

Table I
DISTRIBUTION OF CASES

Treatment	No.	Tubal Patency	IUP	EP
Salpingostomy	9	5	3	1
Methotrexate	3	1	1	0
Expectant Treatment *	4	2	1	0

* One resorted to salpingostomy and another subjected to methotrexate therapy.

(range 15-60 days).

Criteria for abandoning expectant management

Criteria for surgical interference or medical treatment includes increase in pain and tenderness and increase in size of pelvic mass alongwith active intra peritoneal bleeding and rise of B-hCG level.

OBSERVATION

Four cases regressed spontaneously. One required surgical intervention after four days of follow up when the signs and symptoms increased with evidence of intraperitoneal bleeding. The subject who had intramuscular methotrexate was initially booked for expectant management but after 7 days the pain started increasing with increased adnexal tenderness, increase in tubal mass but displaying no significant peritoneal fluid.

We decided to treat her with a single dose of 50 mg methotrexate IM. The pain persisted for three days, then the mass gradually disappeared. Hysterosalpingography was done in four subjects after 3-4 regular menstrual cycles, two of them revealed patent tube on the affected side and one of them conceived.

In 1955 Lund selected 119 haemodynamically stable cases of EP for expectant management. The diagnosis was based on clinical findings and qualitative pregnancy tests (Aschheim-Zondec and Friedman tests) without the aid of laparoscopy or pelvic sonography. While 60% resolved spontaneously, 40% required laparotomy.

Today laparoscopy is often called for confirmation of EP. Some workers studied expectant management in selected cases but only after confirmation of diagnosis by laparoscopy or even laparotomy (Mashiach et al 1982, Carp et al 1986). However, when diagnostic laparoscopy is required for confirmation of EPs, subsequent expectant treatment becomes less attractive, because of possible subsequent risk of haemorrhage.

Non-laparoscopic diagnosis of ectopic pregnancy

Ylostalo et al 1992, studied 318 cases of EP and found expectant management was possible in 83 (26%) cases. 57 (18% of total EPs) had spontaneous regression and 26 required surgical intervention. All the patients were diagnosed presumptively without the aid of laparoscopy.

Our identification was based on indirect evidence such as failure to demonstrate intra uterine pregnancy by TVS with hCG level around 1000-1500 miu/ml. If the patient displays a rising hormone level after endometrial currettage and the curetted specimen fails to reveal chorionic villi by naked eye examination after floating in normal saline and on histopathology, the diagnosis is established presumptively (Das et al 1995).

Korhonen et al 1994 studied the hCG dynamics during expectant management in 118 cases and observed that the rate of decrease in the level of hCG in the first seven days after follow up was not specific enough to prognostic status.

The slow resolution, the need for frequent monitoring and prolonged

6. To avoid prolonged uncertainty, single dose of methotrexate has been shown to be effective but needs further evaluation.

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