CASE REPORT

RUPTURED OVARIAN ECTOPIC PREGNANCY IN TUBERCULOSIS PATIENT: A CASE REPORT

Pariksha Jain¹, Sachin Wankhede², Kshama Kedar³

HOW TO CITE THIS ARTICLE:

Pariksha Jain, Sachin Wankhede, Kshama Kedar. "Ruptured Ovarian Ectopic Pregnancy in Tuberculosis Patient: A Case Report". Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 17, April 28; Page: 4581-4583, DOI: 10.14260/jemds/2014/2478

ABSTRACT: BACKGROUND: Ovarian pregnancy is seen rarely. Diagnosis is based on criteria established in 1878 by Spiegelberg. It is often done during surgery and requires histological consideration. The condition has not been reported locally and its diagnosis is easily missed. **CASE:** A 26 Years old women, primigravida with history of pulmonary tuberculosis in past presented with acute abdomen and clinical picture suggestive of ectopic pregnancy. Ultrasound showed a complex right adnexal mass. On exploration, was found to be ruptured ovarian pregnancy. Right partial oophorectomy was done. Histopathology report confirmed the diagnosis of ovarian ectopic. **CONCLUSION:** Ovarian ectopic is rarest of the rare condition which present late and is hazardous for the reproductive status of a women.

KEYWORDS: ovarian pregnancy, ectopic pregnancy, tuberculosis.

INTRODUCTION: Primary ectopic ovarian pregnancy is seen rarely. The incidence of such pregnancies varies from 0.001% to 0.013% of normal pregnancies and from 0.17% to 1% of ectopic pregnancies.¹ A rare case of primary ovarian ectopic on antituberculous treatment for pulmonary Koch's made it still rarer and prompted us to report this case.

CASE REPORT: A 23 year old female married since 3 months with 41 days amenorrhea, complained of severe nausea & vomiting with mild lower abdominal pain but no associated vaginal bleeding. Her urine pregnancy test was negative. Patient was a diagnosed case of pulmonary Koch's taking antituberculous drugs since 5 months. On examination, the patient looked pale with slight discomfort, pulse rate 108/minute, BP 90/60 mm Hg. Abdomen was slightly distended and tender. On P/V examination cervix, vagina was normal and uterus was of normal size. Cervical movements were extremely tender and right adnexa was palpable. Ultrasonography revealed a right adnexal mass of 5.6cm×4.8 cm with minimal free fluid in cul de sac. Right ovary was not visualized separately from the mass.

On exploration, hemoperitoneum of 1000 ml with grossly normal fallopian tubes and left ovary except for the flimsy adhesions in pouch of Douglas and peritubal region. The right ovary was enlarged, hemorrhagic, (Fig. 1) showing rupture of the tunica albuginea. Right partial oophorectomy with adhesiolysis was done and tissue sent for histopathology. Cut section showed placental tissue and blood clots grossly and were surrounded by ovarian stroma and some yellow corpus luteal tissue. The fallopian tubes showed no evidence of any products of conception. The ovarian tissue microscopically showed ovarian stroma, corpus luteum and products of conception.

DISCUSSION: Ovarian pregnancy is a rare event. Reports vary from one in 2100 to 60, 000, making ovarian pregnancy 1 to 3% of all ectopic pregnancies². Patient was a diagnosed case of pulmonary

CASE REPORT

tuberculosis with evidence of chronic pelvic inflammation. Other risk factors include previous pelvic inflammatory disease, IUCD use, endometriosis, and assisted reproductive technologies.²

The case presented with minor complaints viz nausea and vomiting with mild lower abdominal pain. In a study of six cases of ovarian pregnancy, Comstock et al² found abdominal pain and light vaginal bleeding to be common presenting symptoms. Diagnosis of ovarian ectopic is frequently missed because of its late presentation and mild symptoms.

In 1878, Spiegelberg³ described four criteria for the pathologic diagnosis of ovarian pregnancy:

- The tube has to be entirely normal.
- The gestational sac has to be anatomically located in the ovary.
- The ovary and the gestational sac have to be connected to the uterine ovarian ligament.
- Placental tissue has to be mixed with ovarian cortex.

The conditions most commonly confused with ectopic ovarian pregnancy, both clinically and pathologically are ruptured hemorrhagic corpora lutea, "chocolate" cysts and ruptured tubal ectopic pregnancies. Patient satisfied all these criteria's. Ultrasound is routinely used as a baseline investigation. Appearance of a wide echogenic ring on the ovary, frequently with a yolk sac or fetal parts is suggestive of ovarian gestation. Doppler ultrasonography seems to offer little additional diagnostic value due to the high vascularity of the ovary.² Diagnostic laparoscopy frequently is required to make the diagnosis of ovarian pregnancy, which is only later confirmed by histological examination of removed tissue.⁴

Treatment of ovarian pregnancy usually requires oophorectomy or wedge resection of the ovary. Seiner⁵ et al reported a series of eight patients treated with conservative ovarian surgery with no persistent pregnancies. Einkenkel⁶ et al reported a case of primary ovarian pregnancy which was treated with laparoscopic cystectomy. Medical management with methotrexate may be an option if there remains persistent trophoblastic tissue after Laparoscopy.⁶ If future fertility is desired, wedge resection may be considered.⁶ Oophorectomy should be reserved for cases of advanced gestation. Partial oophorectomy was done considering the primigravida status of the patient. Subsequent pregnancy has been usually uncomplicated⁵.

REFERENCES:

1. Mitra J. and Das PC. Primary Ovarian Pregnancy (with a case report). J Obstet Gynaecol India. 1973; 23: 509-513.
2. Comstock C, Huston K, Lee W. The ultrasonographic appearance of ovarian ectopic pregnancies. Obstet Gynecol 2005; 105(1): 42-46. PMID: 15625140.
3. Gerin Lajoie L. Ovarian Pregnancy. Amer J Obstet Gynaecol. 1951; 62: 920-929. PMID: 14885275.
4. DeSeta F, Baraggino E, Strazzanti C, DeSanto D, Tracanzan G, Guaschino S. Ovarian pregnancy: a case report. Acta Obstet Gynecol Scand 2001; 80: 661-662. PMID: 11437727.
5. Seiner P, DiGregorio A, Arisio R, Decko A, Crana F. Ovarian pregnancy and operative laparoscopy: report of eight cases. Hum Reprod 1997; 12(3): 608-610. PMID: 9130768.
6. Einkenkel J, Baier D, Horn LC, Alexander H. Laparoscopic therapy of an intact primary ovarian pregnancy with ovarian hyperstimulation syndrome. Hum Reprod 2000; 15(9): 2037-2040. PMID: 10967011.

CASE REPORT

Fig. 1: Photograph showing right sided ruptured ovarian ectopic gestation

AUTHORS:

1. Pariksha Jain
2. Sachin Wankhede
3. Kshama Kedar

PARTICULARS OF CONTRIBUTORS:

1. Clinical Associate, Department of Obstetrics and Gynaecology, Indira Gandhi Government Medical College.
2. Associate Professor, Department of Obstetrics and Gynaecology, Indira Gandhi Government Medical College.
3. Associate Professor, Department of Obstetrics and Gynaecology, Indira Gandhi Government Medical College.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Pariksha Jain,
I-301, Rashmi Tanmay,
Eden Rose, Beverly Park,
Near Cinemax (E) – 401107.
E-mail: drpari1702@gmail.com

Date of Submission: 01/04/2014.
Date of Peer Review: 02/04/2014.
Date of Acceptance: 10/04/2014.
Date of Publishing: 25/04/2014.