ISSN: 2581 – 3633
PubMed - National Library of Medicine - ID: 101745081

International Journal of Medical Science and Advanced Clinical Research (IJMACR)

Available Online at:www.ijmacr.com

Volume – 6, Issue – 3, June- 2023, Page No. : 241 - 245

A Study on Presentation and Management of Ectopic Pregnancy At A Tertiary Care Hospital

[1]Dr Anuja Patil, Post Graduate resident, Department of Obstetrics and Gynaecology, M. R. Medical College, Gulbarga.

[2]Dr Suman Umeshchandra, Professor, Department of Obstetrics and Gynaecology, M. R. Medical College, Gulbarga.

[3]Dr Neeta Harwal, Professor and head of the department, Department of Obstetrics and Gynaecology, M. R. Medical College, Gulbarga.

Corresponding Author: Dr Anuja Patil, Post Graduate resident, Department of Obstetrics and Gynaecology, M. R. Medical College, Gulbarga.

How to citation this article: Dr Anuja Patil, Dr Suman Umeshchandra, Dr Neeta Harwal, "A Study On Presentation And Management of Ectopic Pregnancy At A Tertiary Care Hospital", IJMACR- June- 2023, Volume – 6, Issue - 3, P. No. 241 – 245.

Type of Publication: Original Research Article

Conflicts of Interest: Nil

Abstract

Introduction: Ectopic pregnancy and its consequences are the most severe form of obstetric emergency during first trimester of pregnancy. It is a life threatening emergency leading to significant maternal morbidity and even mortality.

Aim: To study the high risk factors and to know the types of clinical presentation, method of diagnosis, treatment and the outcome.

Methodology: A prospective study was conducted at a tertiary care teaching hospital Gulbarga from 1st October 2020 to 30th September 2022. All cases of ectopic pregnancy which were admitted and managed during this period were included in the study. All collected data were analyzed.

Results: Total 30 cases were studied. Classical symptoms of amenorrhea, pain abdomen and bleeding per vaginum were observed in 60% cases. In most of the cases, there was no identifiable risk factor. One patient had h/o previous ectopic pregnancy followed by ipsilateral salpingectomy. One more patient had h/o laparoscopic tubal surgery for tubal blockage. All cases were diagnosed using Transabdominal sonography and Beta-Human Chorionic Gonadotropin with urine pregnancy test correlation. All cases were managed surgically except two cases in which medical management with methotrexate alone benefitted. Most cases were multigravida and common between 22 -32 years age group (63.33%). Right sided Tubal ectopic pregnancy was common (73.3%). EP was present in ampullary region in 43.3% cases. 80% of the s

Conclusion: Use of ultrasonography and human chorionic gonadotropin assay serve as valuable adjuncts to early diagnosis and management. Ectopic pregnancy

mostly presents as an obstetrics emergency in our hospital with ruptured ectopic pregnancy with haemoperitoneum. Therefore, early diagnosis and timely intervention is necessary to decrease the mortality rate.

Keywords: Ectopic pregnancy, Obstetric emergency, salpingectomy, Beta-Human Chorionic Gonadotropin, methotrexate, ampullary region, hemoperitoneum, blood transfusion.

Introduction

Ectopic pregnancy is one of the commonest cause of obstetric emergency as well as maternal morbidity and mortality during first trimester of pregnancy. Management of ectopic pregnancy has changed and improved over time.

In 1903 J. Whitridge Williams said following words regarding management of ectopic pregnancy - "As soon as an unruptured extra-uterine pregnancy is positively diagnosed, its immediate removal by laparotomy is urgently indicated, since rupture may occur at any time and the patient die from haemorrhage before operative aid can be obtained.

But in present scenario, we have multiple options like medical, surgical route via laparotomy or laparoscopy to manage ectopic pregnancy. Still ectopic pregnancy remains the leading cause of early pregnancy related death.

Ectopic pregnancy and its consequences contributes approx. 19% of maternal near miss with case fatality index of 2.85%. It is responsible for 4.34% of maternal mortality even in today's scenario based on a study .

In this background, we have conducted the present study to identify the high risk factors and to know the types of clinical presentation, method of diagnosis and mode of management and outcome of management of ectopic pregnancy in our tertiary care teaching hospital.

Materials And Methods

Study design : A prospective observational study

Conducted at our tertiary care Centre, Mahadevappa Rampure Medical College , Karnataka , India.

The Study duration was from 01 october 2020 to 30th september 2022. The institutional ethical approval was taken prior to conduct of the study. Informed consents were taken from all patients who participated in the study.

Sample size : The study population comprised of patients with ectopic pregnancy who had reported to Obstetrics and Gynaecology department and there after admitted and managed. During the study period total number of 30 cases were admitted with diagnosis of ectopic pregnancy.

Inclusion criteria

All patients with ectopic pregnancy who were admitted and managed during the study period.

Exclusion criteria

Patients who refused hospital admission in view of medical management

Parameter and statistical analysis

Demographic profile of patients, clinical signs and symptoms, obstetric parameters like gravida, parity, risk factors for EP, site and side of ectopic pregnancy, mode of diagnosis and management and the requirement of blood transfusion were recorded.

Results

During the study period total 30 patients were attended and admitted with ectopic pregnancy. The mean age group of study population was 25.5±2.14 (1 SD) yrs and range of patients age were 19 to 32 years (Median age 25 yrs).

In most of the cases, there was no identifiable risk factor. One patient had h/o previous ectopic pregnancy f/b

ipsilateral salpingectomy. One more patient had h/o laparoscopic tubal surgery for tubal blockage. In the study population, it was found that ectopic pregnancy was highest in primigravida (40%) and 20% among second Gravida and 33.3% in third Gravida.

96.6% of patient (29/30) with no past history of ectopic pregnancy were admitted and treated (Table 1). Overall 75.5% of ectopic pregnancies were found on right side (22/30), and 26.6 % had left sided ectopic pregnancy. Total ruptured cases of ectopic pregnancy were 76.6% (23/30).

Most common site of rupture of ectopic pregnancy was ampulla of fallopian tube i.e 53.3% (16/30). 13.3 % patients had isthmic ectopic pregnancy and 13.3 % had interstitial pregnancy, one was at cornuo-isthmic junction. 70% of the patients needed blood transfusions. UPT was positive in 96.6 % of the cases(Table 2).

Table 1: Distribution of patient according to demography and clinical history.

Characteristics		Frequency (n)	Percentage (%)
RELIGION	Hindu	24	80
	Muslim	6	20
Age group in yrs	19-25	21	70
	26-32	13	43.3
Gravida	1	12	40
	2	6	20
	3	10	33.3
	4	1	3.33
Parity	0	12	40
	1	10	33.3
	2	8	26.6
Abortion	0	24	80
	1	6	20
h/o ectopic	1	1	3.33

Table 2: Distribution of different clinical parameter of study population.

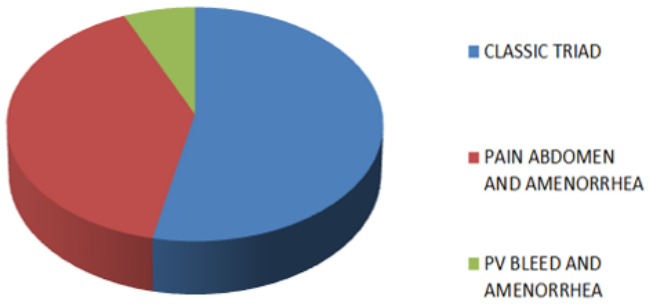
Characteristics		Frequency (n)	Percentage (%)
1.Side	Right	22	75.5
	Left	8	26.6
2.Site of ectopic pregnancy	Ampulla	16	53.3
	Isthmus	4	13.3
	Interstitial	4	13.3
	Cornuo-isthmic junction	1	3.33
3.Ruptured with Hemoperitoneum	Yes	23	76.6
	No	7	23.3
4.Blood transfusion	Yes	21	70
	No	9	30
5.UPT	Positive	29	96.6
	Negative	1	3.33

Classical triad of ectopic pregnancy i.e amenorrhoea, pain lower abdomen and bleeding per vaginum was only present in 53.3% of cases.

In our study group we found 40% of cases with pain lower abdomen and amenorrhea. Only 6.6 % had amenorrhea with PV spotting. Urinary BHCG test was negative only in 90.62% of cases.

All cases were diagnosed using TAS and Beta-HCG with UPT correlation. 27 cases were managed surgically where emergency laparotomy and ipsilateral salpingectomy was done.

In 3 cases, medical management with methotrexate alone benefitted. 20 out of 30 cases (66.6%) were administered blood and blood products (Packed RBC/ FFP) in perioperative/post operative period (Table 2).



Graph 1

Discussion

The first diagnosis of ectopic pregnancy as cause of maternal mortality was known to us in eleventh century. In 1759 the report of first successful surgical management of ectopic pregnancy was made by Surgeon Dr John Bard, New York USA. Salpingectomy as surgical intervention for ruptured ectopic was first done by Scottish surgeon Dr Robert Lawson Tait in 1883.3 Thereafter salpingectomy became a standard practice for management of ruptured ectopic pregnancy The incidence of ectopic pregnancy has increased since last few decades due to increased adoption of medically assisted reproductive (MAR) technique. However, the morbidity and mortality are decreasing due to advancement of medical technique, early detection and increased awareness of the condition. A study conducted by Samiya Mufti et al at LD Hospital Srinagar J&K reported the incidence of ectopic pregnancy was 3.99 per 1000 deliveries.4 Royal College of Obstetrics and Gynaecolgist (RCOG) in their guidelines reported the incidence of ectopic pregnancy in UK was 11 per 1000 deliveries.5

There was no much identifiable predisposing factors for ectopic pregnancy, but one patient had h/o previous ectopic pregnancy f/b ipsilateral salpingectomy. One more patient had h/o laparoscopic tubal surgery for tubal blockage..6 Nulliparous ladies were more prone to have ectopic pregnancy than multiparous ladies. Our study is also consistence with the finding of the study reported by Prasanna B et al.7

Several studies suggested tubal ectopic pregnancy has been affected right side more than left side.6,8 Our study also found the frequency of ectopic pregnancy on right side was more than that of left side.

The classical presentation of ectopic pregnancy is characterized by triad of amenorrhoea, pain abdomen and vaginal bleeding or spotting.1 Present study has revealed only 53.3% cases presented with classical triad. Pain abdomen were the most common presentation and our findings were consistent with the published studies of Gupta R et. Al.9 Approx. 70% cases required blood transfusion in our set up. These finding were consistent with other studies from India.10

Conclusion

Ectopic pregnancy is still one of the major contributor of early pregnancy emergency admissions, morbidity and mortality.

Ectopic pregnancy mostly presents as an obstetric emergency in our hospital with ruptured ectopic pregnancy with haemoperitoneum.

Majority cases presented with pain abdomen and amenorrhea and PV bleed.

Use of ultrasonography and human chorionic gonadotropin assay serve as valuable adjuncts to early diagnosis and management.

High degree of clinical suspicion , early diagnosis and timely intervention are main stay for successful outcome and mortality rate can be decreased.

References

1. Cunningham F, Gray LKJ, Bloom SL, Jodi D, Hoffman S, Barbara L, et al. Ectopic Pregnancy. In: Cunningham F Gray LKJ, Bloom S L, Dashe Jodi S, Hoffman Barbara L, Casey Brian M,Spong Catherine Y, editor. Williams Obstetrics. 25th ed: McGraw-Hill Education; 2018;371-87.
2. Chaudhuri S, Nath S. Life-threatening Complications in Pregnancy in a Teaching Hospital in Kolkata, India. J Obstetrics and Gynecol India. 2019;69(2):115-22.
3. Chaudhary P, Manchanda R, Patil VN. Retrospective study on laparoscopic management of ectopic pregnancy. J Obstetrics and Gynaecol India. 2013;63(3):173-6.
4. Mufti S, Rathe S, Mufti S, Rangrez RA, Khalida W. Ectopic pregnancy: an analysis of 114 cases. JK-Practitioner. 2012;17(4):20-3.
5. Diagnosis and Management of Ectopic Pregnancy: Green-top Guideline No. 21. BJOG : an international J Obstetrics and Gynaecol. 2016;123(13):e15-e55.
6. Sudha VS, Delphine RT. A retrospective study on ectopic pregnancy: a two year study. Int J Reprod Contracept Obstet Gynecol. 2016;5:4365-8.
7. Prasanna B, Jhansi CB, Swathi K, Shaik MV. A study on risk factors and clinical presentation of ectopic pregnancy in women attending a tertiary care centre. IAIM, 2016;3(1):90-6.
8. Islam A, Fawad A, Shah AA, Jadoon H, Sarwar I, Abbasi AU. Analysis Of Two Years Cases Of Ectopic Pregnancy. J Ayub Medical College, Abbottabad: JAMC. 2017;29(1):65-7.
9. Shukla DB, Jagtap SV, Kale PP, Thakkar HN. Study of ectopic pregnancy in a tertiary care centre. Int J Reprod Contracept Obstet Gynecol. 2017;6:975-9.
10. Murugesan A, Prabhu K, Muthulakshmi M. A retrospective study of ectopic pregnancies in a tertiary care hospital. Int J Reprod Contracept Obstet Gynecol. 2016;5:2537-40.