

Large Intact Tubal Ectopic Pregnancy Removed via Laparoscopy

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There has been a rise in the incidence of ectopic pregnancies since 1970. Ninety-five percent of ectopic pregnancies occur in the fallopian tube. When these are managed surgically, a laparoscopic approach is usually pursued.

CASE

A 26-year-old G2 P1011 LMP presented to the emergency department complaining of intermittent suprapubic pain for 2 weeks. The pain was sharp, sudden in onset, 10/10 in severity, occasionally associated with nausea and vomiting, and sometimes alleviated by Advil®. The patient began experiencing 10/10 pain on the morning of presentation that radiated to the epigastric region and did not improve with Advil. It was decreased to an 8/10 pain with hydrocodone. She had 2 bouts of emesis and was not able to tolerate a solid diet.

The patient claimed to have an intrauterine device (IUD) for 4.5 years. Initial exam revealed an obese abdomen with diffuse lower abdominal pain, which was worse over the suprapubic region. No rebound/guarding, cervical motion tenderness, or adnexal tenderness was elicited. The cervix was closed/long/posterior, and no IUD strings were visible or palpable. The uterus was not assessable due to body habitus.

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FIGURE 1. Fetus dissected from sac.

Transvaginal ultrasound revealed an anteverted uterus measuring 9×4.6×1.3 cm. Neither IUD nor intrauterine pregnancy was visualized. A well-formed gestational sac was seen in the right adnexa adjacent to the right ovary. The crown rump length measured 3.4 cm and was consistent with 10.1 weeks' gestation measuring 4.3 cm in diameter. A fetal heart rate of 180 beats per minute was noted. The right ovary was 2.3×3.1×2.7 cm and anterior and superior to gestational sac. The left ovary appeared normal. A small amount of free fluid was noted in the cul de sac and adjacent to the uterine fundus. No free fluid was found in the Morison pouch.

The patient was taken to the operating room for a diagnostic laparoscopy and pos-

sible right salpingectomy. Upon entering the abdomen, approximately 1.5 L of blood and clots were visualized. After removal of the clots and blood, the ectopic fetus was visualized in the isthmic portion of the right fallopian tube. The left fallopian tube was noted to be adherent to the sidewall. A normal uterus and left ovary were visualized.

A right salpingectomy was performed using the Gyrus cutting forceps. The fallopian tube was grasped proximal to the



FIGURE 2. Fetus in formaldehyde. Pathology revealed a tan intact fetus with a foot length of 0.5 cm, a crown to rump length of 4.5 cm, and head circumference of 4.5 cm. A foot length of 0.5 cm corresponds to approximately 10 weeks' gestation.

ectopic pregnancy and cauterized in overlapping bites and then transected. The specimen was placed in a 10-mm specimen bag and removed intact through the umbilical incision. On gross examination of the products, an intact fetus with eyes and limbs was noted (Figures 1 and 2).

The patient tolerated the procedure well and was discharged later in the day. The patient followed up 2 weeks later and was doing well.

DISCUSSION

The incidence of ectopic pregnancies in the United States has increased from 4.5 per 1,000 in 1970 to 19.7 per 1,000 in 1992. This rise has been attributed to the increase in sexually transmitted infections and artificial reproductive technologies. Ninety-five percent of ectopic pregnancies are tubal, 2% to 4% cornual, 0.5% ovarian, 0.1% cervical, and 0.03% abdominal.

The typical presentation of ectopic pregnancies is abdominal or pelvic pain

and vaginal bleeding. While our patient did not complain of vaginal bleeding, she complained of abdominal pain unrelieved with oxycodone. She had actually experienced a similar bout of abdominal pain 2 weeks earlier. She did not seek medical care at that time because the pain was resolved with medication and she believed that she could not be pregnant because she had an IUD.

It is rare for ectopic pregnancies to present so late in gestation. In the literature, the average gestational ages of intact and ruptured tubal ectopic pregnancies were 7.2 ± 2.2 weeks and 6.9 ± 1.9 weeks, respectively. The average tubal diameters of ruptured ectopic pregnancies were 4.4 ± 1.8 cm.¹ A PubMed search using the query “intact tubal ectopic pregnancy laparoscopic” produced one case report of the largest laparoscopically removed intact tubal ectopic pregnancy. Yeung and Pasic reported an intact ectopic tubal pregnancy at 9+ weeks' gestation.²

We now report the intact removal of an intact tubal fetus at 10+ weeks with grossly visible limbs. As far as we know, this is the largest tubal pregnancy laparoscopically removed intact. Our case suggests that even more developed ectopic pregnancies may be removed laparoscopically, thus decreasing hospitalization time and morbidity in comparison to an exploratory laparotomy.

The authors report no actual or potential conflicts of interest in relation to this article.

REFERENCES

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