

Abstract

Title: Abdominal Ectopic Pregnancy and Current Recommendations for Management: A Case Report

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Background: Ectopic pregnancy is a rare and serious complication and a significant contributor to the morbidity and mortality rates related to pregnancy.¹ Although greater than 90% of cases occur in the fallopian tube, it is possible for implantation in the abdomen or pelvis. Overall occurrence of ectopic pregnancies is about 2% of all pregnancies, with roughly 2.5% interstitially located, 12% isthmic, 70% ampullary, 11% fimbrial, 3% ovarian, and 1.5% abdominally located.⁵

Case Presentation: A 27-year-old female, Gravida 2 Para 0 Abortion 1 with a last menstrual period 7 weeks prior, presented due to worsening abdominal pain for one day, accompanied by nausea and mild vaginal bleeding. Her doctor had been following this pregnancy due to some spotting early in the pregnancy. Prior obstetric history includes a miscarriage six months before pregnancy. She had no history of abnormal pap smears, sexually transmitted infections, or pelvic inflammatory disease.

In the Emergency Department, her beta-hCG level was greater than 5,900. Abdominal exam revealed severe tenderness to palpation in the right lower quadrant and generalized tenderness throughout. Mild rebound tenderness and voluntary guarding were present in the left upper quadrant. Pelvic ultrasound revealed a single gestational sac with a yolk sac and embryo located in the right cornua or right fallopian tube near the cornua. Trace free fluid in the pelvis was also noted. The case was managed with an operative laparoscopy; however, due to the location and how firmly the ectopic was adhered to the pelvis, it could not be fully excised. Therefore, a two-dose regimen of methotrexate was also given postoperatively.

Conclusion: There has yet to be a therapeutic protocol established for the management of ectopic abdominal pregnancy due to the complexity of such cases. Current literature advocates laparoscopic management when diagnosed earlier than 12 weeks.⁷ Although not preferred, medical management with methotrexate can be considered when the risk of hemorrhage is too severe for surgical intervention.⁷ If concern for perioperative hemorrhage, laparotomy historically was preferred; however, some now argue that with the advancements of technology and skills of the surgeon, laparoscopy can successfully manage these cases.⁷