


ECTOPIC PREGNANCY QUESTIONARY

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A woman presents with amenorrhoea of 2 months duration; lower abdominal pain, facial pallor, fainting and shock. Diagnosis is:

- a. Ruptured ovarian cyst
- b. Ruptured ectopic pregnancy
- c. Threatened abortion
- d. Septic abortion

ANSWER

b. Ruptured ectopic pregnancy

Young lady presents with acute abdominal pain and history of 1½ months amenorrhoea, on USG examination there is collection of fluid in the pouch of douglas and empty gestational sac. Diagnosis is:

- a. Ectopic pregnancy
- b. Pelvic hematocele
- c. Threatened abortion
- d. Twisted ovarian cyst

Ans. is a i.e. Ectopic pregnancy

Young lady presenting with history of:

- Amenorrhea
- Abdominal pain

On USG:

- Collection of fluid in pouch of douglas
- Empty gestational sac Indicate • Ectopic pregnancy Also Know:

USG findings in case of ectopic pregnancy:

- Transvaginal/ultrasound is the investigation most commonly done to diagnose ectopic pregnancy.

Diagnostic features are:

- Absence of intrauterine pregnancy with positive pregnancy test
- Fluid in the pouch of Douglas (Cul-de-sac).
- Adnexal mass clearly separated from the ovary.
- Gestational sac in the adnexa surrounded by a hyperechoic ring (Bagel sign/ tubal ring sign).
- Rarely cardiac motion may be seen in an unruptured tubal ectopic pregnancy.



Causes of ectopic pregnancy include
except:-

- a. IUCD
- b. Tubal ciliary damage
- c. Blighted ovum
- d. Tubal surgery



ANSWER

(C) Blighted ovum



Basanti, a 28 years aged female with a history of 6 weeks of amenorrhoea presents with pain in abdomen; USG shows fluid in pouch of douglas. Aspiration yields dark color blood that fails to clot. Most probable diagnosis:-

- ▶ a. Ruptured ovarian cyst
- ▶ b. Ruptured ectopic pregnancy
- ▶ c. Red degeneration of fibroid
- ▶ d. Pelvic abscess

Ans. is b i.e. Ruptured ectopic pregnancy

Symptoms In Ectopic pregnancy triad of:

Amenorrhea (seen in 75% cases) followed by Abdominal pain (seen in 100% cases, it is the most consistent symptom of ectopic pregnancy).

Appearance of vaginal bleeding are seen:

The above triad may be accompanied by nausea, vomiting, fainting attacks or syncope.

Patient may present in shock with pallor, tachycardia, hypotension and cold clammy extremities, if ectopic pregnancy has rupture

Examination:

On Bimanual examination –

Vaginal mucosa appears blanched.

Uterus: normal size/slightly bulky.

Extreme tenderness on cervical movement


Fornices-tender (Remember - tenderness in pelvis is the most constant sign of Ectopic pregnancy). – U/L

adnexal mass: is palpable in one third to half of patient.


Culdocentesis:

- It is a simple technique used to identify hemoperitoneum.
- Fluid is aspirated from cul-de-sac via posterior fornix with the help of a needle.
- If non clotting blood is obtained, it is indicative of an intraperitoneal bleed and probably a ruptured ectopic.

Note: If the aspirated blood clots, it may have been obtained from an adjacent blood vessel rather than from bleeding ectopic pregnancy.



▶ A young woman with six weeks amenorrhea presents with mass abdomen. USG shows empty uterus. Diagnosis is:

- a. Ovarian cyst
 - b. Ectopic pregnancy
 - c. Complete abortion
 - d. None of the above
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Ans. is b i.e. Ectopic pregnancy

a young woman presenting with 6 weeks of amenorrhea and USG showing empty uterus could either mean it is an ectopic pregnancy or abortion.

In abortion – patient will give history of bleeding, pain but mass in abdomen does not favour it.

Most important investigation for ectopic pregnancy:

- a. TVS
- b. Serial b-hCG levels
- c. Doppler USG
- d. Progesterone
- e. Culdocentesis

b i.e. Transvaginal USG

“As explained earlier transvaginal ultrasound is the best available diagnostic modality for diagnosing ectopic pregnancy. Vaginal sonography yields correct pre-operative diagnosis of ectopic pregnancy in 91% cases. It decreases the need for diagnostic laparoscopy or curettage or both to establish the diagnosis of ectopic pregnancy.

Indications of medical management in ectopic pregnancy:

- a. Presence of fetal heart activity
- b. Size <4 cm
- c. Gestation <6 week
- d. α -hCG >1500
- e. β -hCG <15000

ANSWER

(b) Size $< 4\text{cm}$

True statement regarding ectopic pregnancy:

- a. Serum progesterone >25 ng/ml exclude ectopic
- b. b-hCG levels should be >1000 mIU/ml for earliest detection by TVS
- c. b-hCG levels should be <1000 mIU/ml for earliest detection by TVS
- d. Methotrexate is used for treatment

Ans. is a, b and d

Serum progesterone >25 ng/ml exclude ectopic

“Serum progesterone—Level greater than 25 ng/ml is suggestive of viable intrauterine pregnancy whereas level less than 5 ng/ml suggests an ectopic or abnormal intrauterine pregnancy.” So option a is correct

“The lowest level of serum β -hCG at which a gestational sac is consistently visible using TVS (discriminatory zone) is 1500 IU/L. The corresponding value of serum β -hCG for TAS is 6000 IU/L. When the β -hCG value is greater than 1500 IU/L and there is an empty uterine cavity, ectopic pregnancy is more likely.” So options c is absolutely incorrect,

option d can be taken as partial correct\ Methotrexate is the drug of choice for medical management of ectopic pregnancy i.e. option d is correct

“Estimation of β -hCG in ectopic pregnancy: Urine pregnancy test—ELISA is sensitive to 10-50 mIU/ml and are positive in 95% of ectopic pregnancies. A single estimation of β -hCG level either in the serum or in urine confirms pregnancy but cannot determine its location. The suspicious findings are: (1) Lower concentration of β -hCG compared to normal intrauterine pregnancy (2) Doubling time in plasma fails to occur in 2 days.” So



Q. Not true about ectopic pregnancy:

- a. Previous ectopic is greatest risk
- b. Progesterone only pills doesn't increase risk
- c. Increased risk with pelvic infections
- d. Increased risk with IVF
- e. IUCD use increases the risk

ANSWER

(b) Progesterone only pills does not increase risk

Which of the following treatment is not done in ectopic pregnancy:-

- a. Salpingectomy
- b. Salpingo-oophorectomy
- c. Salpingostomy
- d. Resection of involved segment

Ans. is b i.e. Salpingo-oophorectomy

Surgical management of Ectopic pregnancy (laparoscopy or laparotomy)

Conservative surgery

Salpingostomy:

- It is the procedure of choice when the patient is hemodynamically stable and wishes to retain her future fertility

Salpingotomy:

- Seldom done nowadays

Segmental resection and anastomosis:

- It is done in case of isthmic praegnancy.

Fimbrial expression of the ectopic pregnancy:

- Risk of recurrence of ectopic pregnancy are high therefore not commonly performed.


Radical surgery

Salpingectomy


Indications

Ruptured ectopic

- The patient has completed her family,
- The tubes are grossly damaged
- Ectopic pregnancy has recurred in a tube already treated conservatively.
- Uncontrolled bleeding
- Sac size > 5 cm.



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- 



b) Ruptured ectopic pregnancy

A female presents with 8 weeks amenorrhea with pain left lower abdomen. On USG, there was thick endometrium with mass in lateral adnexa. Most probable diagnosis:

- a. Ectopic pregnancy
- b. Torsion of dermoid cyst
- c. Tubo-ovarian mass
- d. Hydrosalpinx

Ans. is a i.e. Ectopic pregnancy

A female with 8 weeks amenorrhea with pain left lower abdomen and on USG, thick endometrium with mass in lateral adnexa is suggestive of ectopic pregnancy

Most common manifestation of ectopic pregnancy is:

- a. Vomiting
- b. Bleeding
- c. Pain abdomen
- d. Shock

Ans. is c i.e. Pain in abdomen

Most common and the most consistent symptom of ectopic pregnancy (undisturbed) is Abdominal pain.

It is seen in 95-100% cases.

Pain is located in the lower abdomen/pelvic region.

It can be unilateral or bilateral.


In case of ruptured ectopic pregnancy:

pain is due to hemoperitoneum and when internal hemorrhage floods the peritoneal cavity and irritates the undersurface of diaphragm and phrenic nerve, the patient also complains of shoulder tip and epigastric pain.

In case of unruptured ectopic pain is due to stretching of Fallopian tube



The cause of fetal death in ectopic pregnancy is postulated as: [

- a. Vascular accident
 - b. Nutritional adequacy
 - c. endocrine insufficiency
 - d. Immune response to mother
- 

Ans. is a i.e. Vascular accident

Ectopic pregnancy is the leading cause of early pregnancy related deaths. Most common cause of death in ectopic pregnancy is tubal rupture → severe haemorrhage → death.

Ectopic pregnancy can have 2 outcomes:

1. Tubal abortion – M/C outcome. Most common outcome in ectopic pregnancy in ampulla end by Tubal abortion
2. Tubal rupture–ectopic pregnancy of isthmus are the ones which usually rupture

In which part of fallopian tube ectopic pregnancy will have longest survival:

- a. Isthmus
- b. Ampulla
- c. Cornua
- d. Interstitium

Ans. is d i.e. Interstitium

M.C site of ectopic pregnancy – Fallopian tubes.

In Fallopian Tubes – M/C sites in descending order are:
Ampulla > mus > infundibulum > interstitium

Rarest overall site of ectopic pregnancy is cervix or cesarean section scan

Average period of survival of ectopic pregnancy is 8 weeks.