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Dr. Mohini Rajoriya
Department of Obstetrics & Gynaecology, M.Y. Hospital & MGM Medical College, Indore, Madhya Pradesh, India

Dr. Gayatri Mathuriya
Department of Obstetrics & Gynaecology, M.Y. Hospital & MGM Medical College, Indore, Madhya Pradesh, India

Correspondence
Dr. Gayatri Mathuriya
Department of Obstetrics & Gynaecology, M.Y. Hospital & MGM Medical College, Indore, Madhya Pradesh, India

To evaluate clinical presentation in case of ectopic pregnancy

Dr. Mohini Rajoriya and Dr. Gayatri Mathuriya

Abstract
Background: Ectopic pregnancy is a grave complication of pregnancy with various clinical presentations. In spite of advances in the field of TVS and beta HCG it still has a high rate of maternal morbidity and mortality.
Aims and objective: To evaluate clinical presentation in case of ectopic pregnancy.
Material and method: The study conducted is a retrospective study in cases of ectopic pregnancy done in Department of Obst & Gynae PCMS &RC Bhopal over a period of 5 years, from Sept 2007-Sept 2012. The criteria analyzed were age, parity, clinical presentation acute or chronic, ruptured and Unruptured.
Results: Out of 71 cases of ectopic pregnancy, age group of patient 18-20 years- 8.45% 21-25years-36.61%, 26-3O years-35.21%, 31-35years 9.85%, age group 36-40 years 9.85% of ectopic found. Out of which 70.4% were multipara. The cases presenting as ruptured pregnancy were 57.74% and unruptured were 30.98% Chronic unruptured ectopic pregnancy were 8.45% and chronic ruptured were 2.81%.
Conclusion: High index of suspicion for diagnosis of ectopic pregnancy in reproductive age group helps in early intervention. Thus it can reduce the maternal morbidity and mortality.
Study Design: Observational Study.

Keywords: Clinical, presentation, ectopic & pregnancy

Introduction
An ectopic pregnancy is one in which the fertilized ovum becomes implanted in a site other than the normal uterine cavity [1] over the last few decades, the incidence of ectopic pregnancy has increased almost to the extent of an epidemic disease. Ectopic pregnancy is one of the commonest acute abdominal emergencies [2, 3]. Ectopic pregnancy remains the leading cause of maternal deaths in early pregnancy [4]. There is an overall increase in incidence of ectopic tubal pregnancy (ETP) and this is probably due to increased awareness, advanced diagnostic tools like transvaginal ultrasonography and estimation of beta subunit of human chorionic gonadotrophin (β-hCG) in serum [5]. Several risk factors for ectopic pregnancy have been identified including pelvic inflammatory disease, smoking, and, previous ectopic pregnancy.

Aims and objectives
Clinical manifestations may be diverse and diagnosis of this condition is often mistaken and delayed leading to increased morbidity and even mortality in these patients. This study was undertaken to study the clinical presentations, ultra sound features and diagnostic difficulties of all cases of ectopic pregnancy that presented to our centre over a period of five years.

Methods
This is a retrospective study conducted at Peoples College of Medical Science and Research Center, Bhanpur Bhopal from September 2007 to September 2012. All women who presented to our hospital with ectopic pregnancy were analyzed from the available hospital documents.

The data collected was in respect to the following:
1. Age
2. Parity
3. Acute presentation
4. Chronic presentation
5. Ruptured ectopic pregnancy
6. Unruptured ectopic pregnancy

Patients with an ectopic pregnancy commonly present with pain and vaginal bleeding between 6 and 10 weeks' gestation. However, these are common symptoms in early pregnancy, with one third of women experiencing some pain and/or bleeding. The pain can be persistent and severe and is often unilateral. However unilateral pain is not always indicative of ectopic pregnancy as, in early pregnancy, a prominent painful ovarian corpus luteum cyst is common. Shoulder tip pain, syncope and shock occur in up to 20% of women and abdominal tenderness in more than 75%. Bimanual examination, if performed at all, should be done cautiously and gently. Cervical motion tenderness has been reported in up to 67% of cases, and a palpable adnexal mass in about 50%. More recently, it has been reported that one third of women with ectopic pregnancy have no clinical signs and 9% have no symptoms [6]. A ruptured ectopic pregnancy should be strongly suspected if a woman has a positive pregnancy test and presents with syncope and signs of shock including tachycardia, pallor and collapse. There may be abdominal distension and marked tenderness. While a bimanual examination may reveal tenderness, cervical excitation and an adnexal mass, great caution is required as this may exacerbate bleeding. As ectopic pregnancy affects young, fit women they are often able to mount remarkable haemodynamic compensation. Tachycardia is a particularly important sign, but decompensation with shock is a sign of significant intraperitoneal bleeding. In an emergency, where the patient has collapsed and there is high clinical suspicion of tubal rupture, extensive clinical examination is inappropriate and immediate surgical intervention is indicated.

Results

Table 1: In the five years study period, there were a total of 71 ectopic pregnancies.

Age	Percentage
18- 20 years	8.45%
21-25 years	36.61%
26-30 years	35.21%
31-35 years	9.85%
36-40 years	9.85%

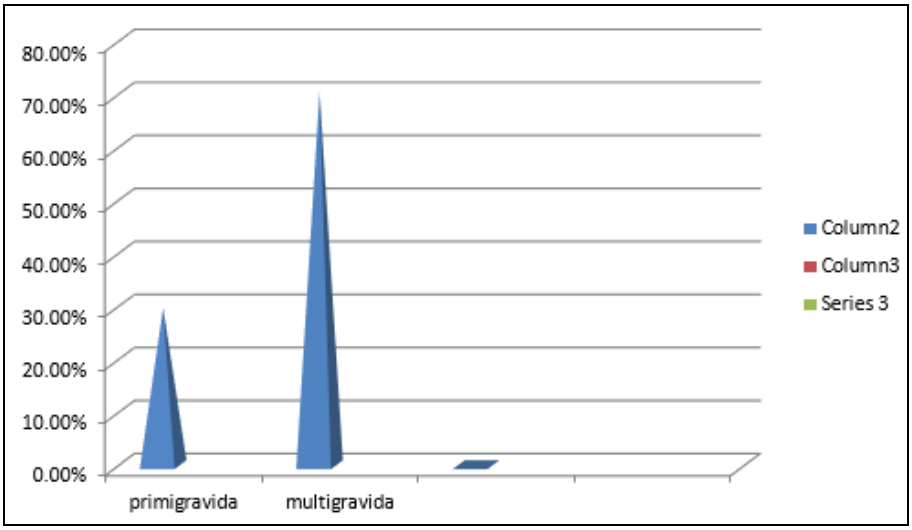

Fig 1: In the five years study period, there were a total of 71 ectopic pregnancies.

Out of 71 cases of ectopic pregnancy, age group of patient 18-20 years- 8.45% 21-25years- 36.61%, 26-3O years-35.21%, 31-35years 9.85%, age group 36-40 years 9.85% of ectopic found. Out of which 70.4% were multipara.

Table 2: Parity distribution in present study**.**

Parity	Percentage
primigravida	29.6%
Multigravida	70.4%

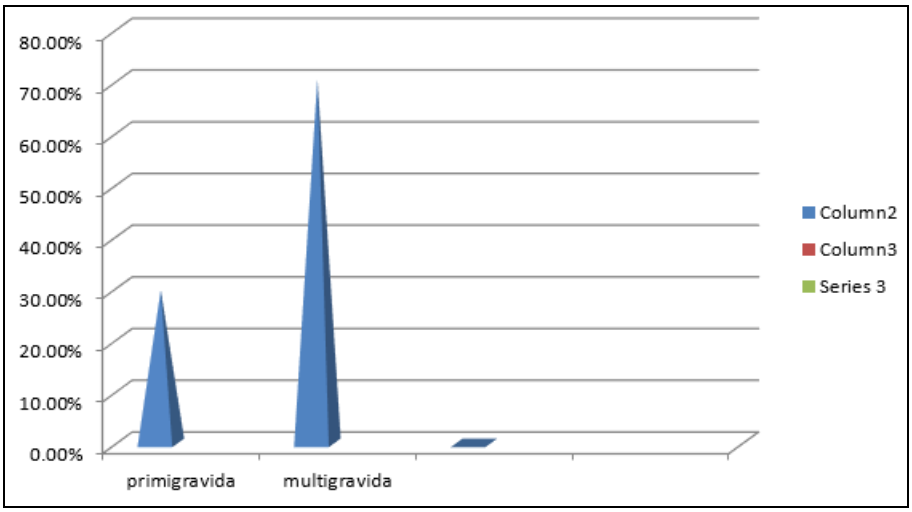

Fig: 2: Parity distribution in present study**.**

Table 3: clinical presentation of ectopic pregnancy in present study.

Clinical presentation	Percentage
Acute ruptured	57.74%
Acute unruptured	30.98%
Chronic ruptured	2.81%
Chronic unruptured	8.45%

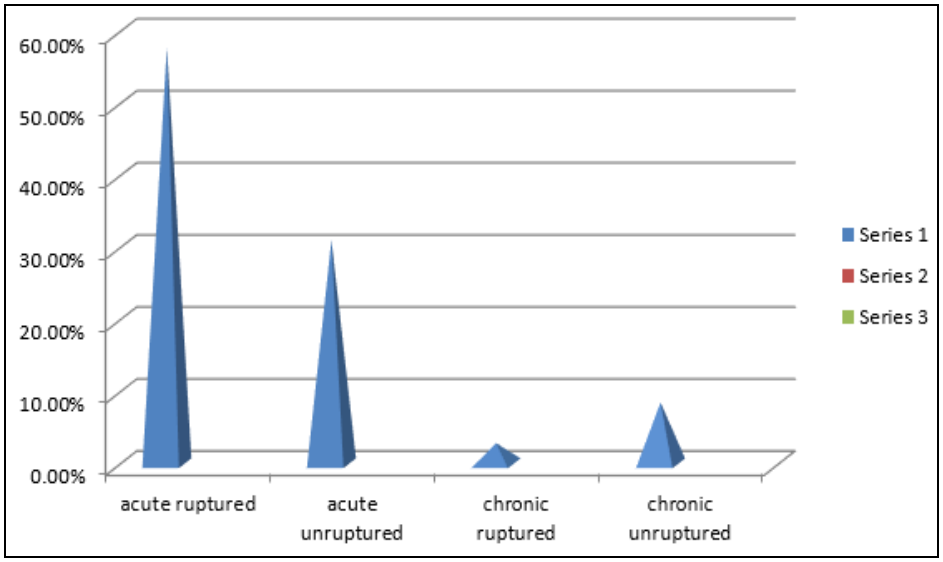

Fig 3: Clinical presentation of ectopic pregnancy in present study.

Discussion

Ectopic pregnancy is an increasingly common and potentially catastrophic condition. Misdiagnosis of ectopic pregnancy is quite common. Delayed diagnosis may endanger the life of the patient but also decreases later the likelihood of a future successful pregnancy [7]. There are a very few other disorders in obstetrics that has so many different presentations. The presentation of the patient may vary, some with minimal symptoms to a patient in a state of shock with massive haemoperitoneum. Some may present as a case of mass abdomen as in chronic ectopic. Vasomotor symptoms causing vertigo and syncope may be thepresentincomplaint. Ectopic pregnancy is a nightmare to the patient and also to the treating obstetrician. In the present study the majority of the patients belonged to the age group 21 -25 years. This is similar to the study by Rakhi *et al* and Poonam *et al*, in which the peak age incidence was 20-25 years [8]. This is in contrast to the study by Arup Kumar etal in which the most common age group affected were 26-30 years (68.57%). Most of the casespresented with ruptured ectopic pregnancy making the scenario clear that still in India most of the patients present late, may be due to failure of making early diagnosis at various level of healthcare delivery system. As a result in our study majority of the women (57.74%) had a laparotomy because of unstable condition and hemoperitoneum. Laparotomy with salpingectomy was the most common modality of treatment in most of the other studies. Since most of our patients were referred with established signs of ruptured tubal pregnancy, and hemodynamic compromise, they needed emergency laparotomy and salpingectomy as life saving measures. High index of suspicion and awareness among clinicians, early use of routine transvaginal ultrasound to locate pregnancy and measuring hCG levels in any women in reproductive age who present with abdominal pain and vaginal bleeding, irrespective of amenorrhea is vital in diagnosing ectopic pregnancy at an early stage. This allows medical management and conservative tubal surgery with better reproductive potential.

Conclusion

High index of suspicion for diagnosis of ectopic pregnancy in reproductive age group helps in early intervention. Thus it can reduce the maternal morbidity and mortality. Surgical management by laparotomy and salpingectomy continues to be the preferred mode of management of ectopic pregnancy in our institution.

References

1. Kumar P, Malhotra N. Ectopic pregnancy. Jefcoat's principles of Gynecology, 2008, 142-59.
2. Challoner K, Incerpi M. Non traumatic abdomino surgical emergencies in the pregnant patients. Emerg Med Clin North Am. 2003; 21(4):971-85.
3. Maymon R, Shulman A, Maymon BB, Bar-Levy F, Lotan M, Bahary C. Ectopic pregnancy, the new gynaecological epidemic disease: review of the modern work up and the non surgical treatment option. Int J fertile. 1992; 37(3):146-64.
4. Department of Health. Why mothers die: a confidential enquiry into the maternal deaths in the United Kingdom. In Drife J, Lewis G (eds): Norwich, UK: HMSO, 2001, 282.
5. Chatterjee S, Dey S, Chowdhury RG. Ectopic pregnancy in previously infertile women-subsequent perregnancy outcome after laparoscopic management. Al A meen J Med Sci. 2009; 2(1):67-72.
6. Walker JJ. Ectopic pregnancy. Clin Obstet Gynecol. 2007; 50:89-99.
7. Jones EE. Ectopic pregnancy: Common and some uncommon misdiagnosis. Obstet Gynecol Clin North Am. 1991; 18:55-72.
8. Poonam Y, Uprety D, Banerjee B. Ectopic pregnancy-two years review from BPKIHS, Nepal. Kathmandu University Med J. 2005; 3:365-9.