

CASE NOTE

Ruptured ectopic pregnancy presenting as intestinal obstruction

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Gynecologic emergencies often present as acute abdominal pain; however, intestinal obstruction owing to a gynecological pathology is rather unusual. We report the case of a woman in whom an adhesive small bowel obstruction developed secondary to a ruptured tubal pregnancy.

CASE REPORT

A 28-year-old woman presented with a 15-day history of colicky, lower abdominal pain that radiated to the whole of her abdomen and that had increased in severity over the past 24 hours. The patient had not passed flatus or feces in the past 5 days except for a small, loose stool on the morning of admission. She had experienced multiple episodes of bilious vomiting before coming to hospital. Her last menstrual period was 25 days before admission. She had received antituberculosis treatment for tuberculous meningitis 5 years previously. On examination, the patient was adequately hydrated but pale. Her pulse rate was 110 beats/min and her blood pressure was 110/70 mm Hg. There was lower abdominal distention with tenderness, although no rebound tenderness or palpable bowel loops were present. We found shifting dullness, and bowel sounds were sluggish. Digital rectal and vaginal examinations were unremarkable.

The patient had a hemoglobin level of 83 g/dL. Radiographs of the abdomen showed dilated small bowel loops and multiple air fluid levels (Fig. 1). We made a provisional diagnosis of subacute intestinal obstruction and initiated conservative treatment. However, the patient reported worsening of symptoms, and we noted a marked increase in abdominal tenderness. We planned an emergency laparotomy with the working diagnosis of strangulation of the bowel. At laparotomy, we drained 1 L of dark-coloured blood from the peritoneal cavity. We found small bowel loops dilated up to the terminal ileum and a loop of ileum adherent to the right fallopian tube with blood clots in the vicinity. There was a ruptured right tubal pregnancy in the ampullary region. We released the adhesions and performed a right salpingectomy. The patient made an uneventful recovery. Histopathologic examination of the resected specimen confirmed a diagnosis of ruptured ectopic pregnancy.

DISCUSSION

It can be difficult to establish an etiological diagnosis of intestinal obstruction preoperatively. Common etiologies of small bowel obstruction include adhesions (including postoperative and tubercular adhesions), neoplasia, hernias, radiation and Crohn disease. A gynecological condition like ectopic pregnancy would unlikely be considered as an underlying cause of intestinal obstruction.

The most common signs and symptoms of ectopic pregnancy include amenorrhea, abdominal pain, irregular vaginal bleeding and pain on abdominal or pelvic examination. A pelvic adnexal mass is palpated in only 50% of the

patients. Unfortunately, the most common signs and symptoms of ectopic pregnancy are correct in predicting only 50% of cases.¹ Abdominal pain is the single most consistent feature of ectopic pregnancy.² Clinicians should have a high index of suspicion for ectopic pregnancy in patients with a previous history of tubal pregnancy, tubal surgery, pelvic inflammatory disease (PID) or tubal disease. Possible differential diagnoses includes PID, acute appendicitis, typhoid enteritis, incomplete septic abortion, uterine fibroid, gastroenteritis, peptic ulcer and intestinal obstruction.³ Catani and colleagues⁴ reported a case of intestinal obstruction due to adhesion from a neof ormation located on the mesenteric side of the ileum. Histologic examination of the specimen revealed an ectopic pregnancy. Orawke and colleagues⁵ reported another case of combined intrauterine and extrauterine pregnancy diagnosed preoperatively as simple intestinal obstruction.

A delay or error in the diagnosis of ectopic pregnancy leads to increased risk of mortality and morbidity including prolonged hospital stay, increased hospital costs and enterocutaneous fistulas.³

Owing to the absence of amenorrhea or vaginal bleeding, the presence of clinical and radiological features of intestinal obstruction and the patient's past history of tuberculous infection, we did not consider an etiological diagnosis of ruptured ectopic pregnancy in our patient. Had we used abdominal ultrasound to assess the patient's acute abdominal pain, we might have discovered her condition

preoperatively. To improve the chances of correctly diagnosing an ectopic pregnancy, admitting staff should obtain accurate menstrual and sexual history, and facilities should be able to provide serum β human chorionic gonadotropin (HCG) levels and transvaginal ultrasound scans.³

In conclusion, abdominal pain is the single most consistent feature of ectopic pregnancy. Ectopic pregnancy should always be considered in every woman of child-bearing age who presents with unexplained abdominal pain, irrespective of history of amenorrhea and vaginal bleeding.² Inclusion of ultrasonography and estimation of β -HCG in the work-up would improve the likelihood of an early and accurate diagnosis, thus facilitating prompt treatment.

Competing interests: None declared.

References

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Fig. 1. Plain abdominal radiographs with the patient in both the upright and supine positions show multiple air fluid levels and dilated jejunal loops.