

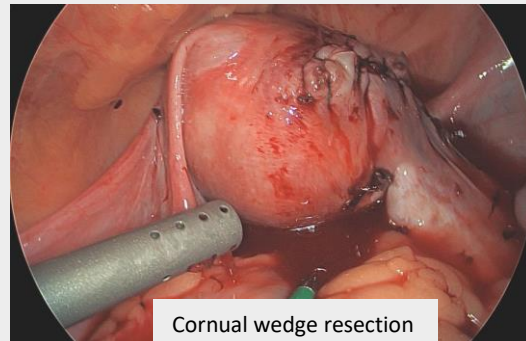
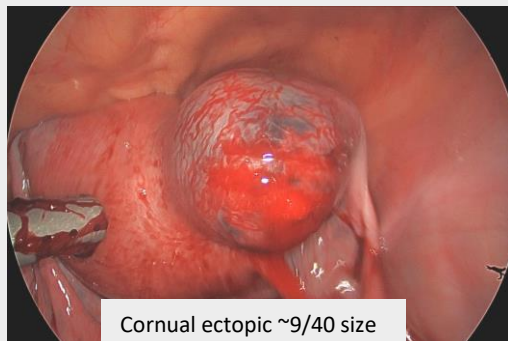
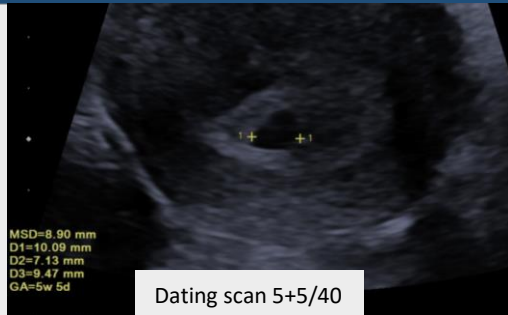
A case of a ruptured cornual ectopic pregnancy three weeks following a medical termination of a presumed viable intrauterine pregnancy.

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Introduction

- Cornual and interstitial ectopic pregnancies are rare, accounting for 1-3% of ectopic pregnancies¹
- Implantation occurs in one of the upper and lateral portions of the uterus (cornual ectopic) or within the proximal, intramural portion of the fallopian tube (interstitial ectopic)¹
- They can be difficult to differentiate from an intrauterine pregnancy on USS²
- They are associated with high morbidity and mortality due to the difficulty in diagnosis and potential for catastrophic haemorrhage²

Images



Case Description (Presentation)

- 32-year-old female, G4P3 (3x previous NVB)
- Presented to ED with severe RLQ pain
- Had medical termination of pregnancy (mTOP) 3 weeks prior for a presumed live intrauterine gestation seen on USS. Had not passed products of conception.
- O/E: BP 80/50mmHg, peritonitic abdomen, no PV bleeding, unremarkable spec examination.
- Urine BhCG positive
- Bedside USS: significant intraperitoneal free fluid and ?gestational sac in R adnexa
- MTP activated
- Taken for emergency laparoscopic management of ectopic pregnancy.

Case Description (Intra-op and Post-op)

- Intra-op findings: 2L haemoperitoneum, right cornual ectopic pregnancy approximately 9 weeks' gestation size, normal tubes and ovaries
- Ectopic was infiltrated with lignocaine and adrenaline and managed via cornual wedge resection and right salpingectomy.
- Total blood products: 8x pRBCs, 5x cryoprecipitate, 4x fresh frozen plasma
- Post-op: good recovery, discharged on day 3 with plan for regular BhCGs until negative
- Encouraged to avoid pregnancy for 24 months.
- Mode of delivery next pregnancy = LSCS

Discussion

- This case demonstrates the difficulty of differentiating a cornual ectopic pregnancy from an intrauterine pregnancy on USS, and the clinical consequences of the same
- It also highlights the importance of follow up from MTOP providers, as this woman should have been further investigated given she had ongoing pain and no passage of products of conception three weeks post-MTOP.