Bilateral Ruptured Tubal Pregnancies Associated With Oral Contraceptives

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BILATERAL ruptured tubal pregnancies are rare conditions. A review of the literature revealed no documented cases. This paper has been written to call attention to this catastrophic entity which occurs from time to time.

Pregnancy involves inherent risks. Unilateral ruptured ectopic pregnancy carries more risk. Unilateral ruptured tubal pregnancy with a contralateral unruptured tubal pregnancy is even more hazardous, especially if the unruptured tube goes unnoticed by the operating surgeon. Bilateral ruptured tubal pregnancies should logically carry the gravest prognosis of the tubal pregnancies. Recent literature available indicates that there are approximately 100 deaths per year in the United States resulting from ruptured tubal pregnancies and intra-abdominal hemorrhage. Peck,[1] cites a mortality rate of 3.6 per cent for bilateral tubal pregnancies and, Danforth, in his latest textbook of Obstetrics and Gynecology cites a mortality rate of 2 per cent for tubal pregnancies in general.[2] This entity then must be considered a major cause of maternal mortality in the United States.

In reviewing the literature one becomes aware of the confusion in reporting cases of bilateral pregnancies in which the second tubal gestation was found incidental to surgery for suspected unilateral ruptured tubal pregnancy. Because of this apparent confusion, the exact number of bilateral tubal pregnancies is not known. It is felt to be a relatively rare occurrence.

Asriel[3] in 1960 quoted Burt et al. and Ross and Desbordes[4] to the effect that up to 1953, only 94 cases of bilateral tubal pregnancies had been reported. Fishbach[5] in 1939, established a positive criterion for a diagnosis of this condition and reported 76 cases from the literature. Abrams and Kantner[6] reported in 1948 that there were 94 acceptable cases and found the incidence to be 1:1,580 ectopic pregnancies, Stewart[7] reports this incidence to be 1:725.

In the literature available to us, we found no documented cases of co-existent bilateral ruptured tubal pregnancy. One author alluded to the existence of this condition, but gave no references.

CASE REPORT

A 22-year-old gravida-O, para-O, was first seen in the office on 7-11-69 requesting a physical examination. Her only complaint was mild lower abdominal discomfort. She had no GI or GU symptoms. She denied amenorrhea and stated that she had been on a sequential oral contraceptive pill for approximately one year. She gave her last menstrual period as having been sometime in June. She had made no attempt to date her periods since being on the pills.

Physical Examination. Temperature 98.8, pulse 76, blood pressure 110/70, weight 137, Hct. 30%. Urine negative. Physical findings were not revealing. The abdomen was scaphoid with mild tenderness in the hypogastric area. There was no guarding or rebound tenderness. Bowel sounds were normal. There was no CVA tenderness. Pelvic examination revealed normal external genitalia. On speculum examation, there was no bleeding but a moderate discharge, suggestive of trichomonas. The cervix was closed and without lesions and was bluish in color. The latter was felt to be due to progestins. The cul-de-sac was flat. On bimanual examination, the cervix was boggy and the uterus was anteflexed and normal size. No adnexal masses were appreciated. There was mild to moderate tenderness in both adnexa. There was no remarkable tenderness on cervical manipulation.

An SC prep, serum Fe and UCG were ordered. She was given a prescription for Feosol spansules and a mild analgesic.

The patient did not have the laboratory work performed. She presented at the office on 8-2-69 stating that

the pain had improved and that she had only mild discomfort. She had a low grade temperature of 100 with essentially unchanged pelvic findings. She was placed on penicillin. On 8-5-69, she called, while shopping, to report that she was "slightly dizzy" and had noticed some spotting. She was urged to come in immediately. At this time the Hct. was 25%, pulse 100, respiration 24, blood pressure 126/80. Pelvic examination was not satisfactory because of exquisite tenderness. She admitted that on occasions she did forget to take her pills but would take two the following day. She was advised to go directly to the hospital but failed to do so. She was admitted several hours later with an initial Hgb. of 8.6 grams and a Hct. of 26%. A stat pregnancy test was positive. The WBC was 9,100, seg 77, Lymphs 22 and Mono 1. The urine was negative for glucose and protein. The pH was 6. There were 2 to 3 WBC per high power field.

D5W in Ringer's was started while blood was being typed. She was taken to surgery and on entering the abdomen, approximately 400 to 500 cc of blood and clots were encountered and aspirated. The uterus was elevated into the operative field. A mass was felt on the right and the right tube was brought into view. A mass was noted to extend from the isthmus to the ampulla with a bleeding rent in the center of the mass. A right salpingectomy was done. Bright red blood was noted to well up continually in the pelvis and on elevating the left tube, another mass in approximately the same location as on the right, and approximately 4 cm. in diameter, was encountered. There was moderate bleeding from a definite rupture. Because the patient had expressed a strong desire for us "to save her tubes if possible," a partial salpingectomy with tuboplasty was done. With hemostasis complete, the abdomen was closed. The post operative course was uneventful.

Pathology Report. The specimen from the right fallopian tube consists of two pieces of tissue. The first is identified as fallopian tube and measures 7.5 cm. in length. The fimbriated end appears intact. The central portion of the structure is greatly dilated and measures 4.5 cm. in greatest diameter. There is hemorrhagic fibrinous material attached to the surface. On section, the lumen contains spongy hemorrhagic material. There is a cavity in the center of this spongy material that measures 1 cm. in diameter. The second piece of tissue is lobular and measures 5.5 x 2.5 x 2 cm. On section there is translucent grumous material.

There are microscopic findings of tubal pregnancy in each fallopian tube. The sections are quite similar showing clotted blood filling the lumina of the tubes and chorionic villi of an equivalent age in both tubes. Vascularization of these villi is poor. There is a decidual type reaction in the linings of both tubes. Trophoblastic activity is not striking. In each instance the second piece of tissue described grossly is organizing blood clot.

Diagnosis. Bilateral ectopic (tubal) pregnancies, ruptured, 7x7-789.

DISCUSSION

A case of co-existent bilateral ruptured tubal pregnancy has been presented.

The paper points up the perplexity of a case of pelvic pain and anemia in an uncooperative patient on oral contraceptives.

The case also demonstrates the necessity of examining both tubes when operating for ruptured tubal pregnancy. A challenge is offered to the research minded for an accurate tabulation of documented cases of bilateral ruptured tubal pregnancies.

One may question the partial salpingectomy on the left tube because of the possibility of a recurrent tubal gestation. This however, had been previously discussed with the patient and her feelings were strong with regards to tubal conservation, even in spite of the possibility of future hazards. Though we feel that the chances of a successful pregnancy is nil, the tuboplasty procedure was important to the psyche of this patient.

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