

Recurrent ectopic pregnancies: A management dilemma

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Abstract

Recurrent ectopic pregnancies can be managed conservatively, medically or surgically and present as a management dilemma for the clinician, in particular if the patient is keen to retain fertility. We report the case of a 25 year old nulliparous woman with a history of 3 previous ectopic pregnancies. The patient was diagnosed with a left ectop-

ic pregnancy, had a successful medical management and presently she is on the waiting list for bilateral salpingectomy prior to her assessment for in vitro fertilization.

Key words: recurrent ectopic pregnancies; salpingotomy; salpingectomy; management

Recurrent ectopic pregnancies can present as a management dilemma for the clinician in particular if the patient is keen to retain fertility. Ectopic pregnancy can be managed conservatively, medically or surgically. We report the case of a young nulliparous patient who had three previous ectopic pregnancies and presented with a fourth ectopic pregnancy, and highlight difficulties in the management of these cases.

Case report

Our case is a 25 year old gravida: 4, para: 0, with 3 previous ectopic pregnancies. She had medical management with methotrexate for a left ectopic pregnancy in 2007, surgical management with right salpingotomy for right ectopic pregnancy in 2010, and medical management with methotrexate for left ec-

topic pregnancy in 2011. She was self - referred to early pregnancy assessment unit with history of bilateral lower abdominal pain and vaginal spotting for few days. The first day of her last menstrual period was 5 weeks prior to presentation and the pregnancy test was positive. Abdominal and vaginal examination was unremarkable. A diagnosis of left ectopic pregnancy was made after no evidence of intrauterine pregnancy with a 10mm well - defined area adjacent to the left ovary seen on transvaginal scan. β -hCG was 2,500. Patient was counselled for both surgical and medical management but declined surgical option in order to preserve her fertility. After further counselling, she accepted medical management with methotrexate which was successful. She is presently on the waiting list for bilateral salpingectomy as requested by the regional fertility unit pri-

or to her assessment for in vitro fertilization (IVF).

Discussion

The Royal College of Obstetricians and Gynecologists recommends a laparoscopic approach to the surgical management of ectopic pregnancy in the hemodynamically stable patient. It also states that in the presence of healthy contralateral tube there is no clear evidence that salpingotomy should be used in preference to salpingectomy. Salpingotomy should be considered as the primary treatment when managing tubal pregnancy in the presence of contralateral tubal disease and the desire for future fertility¹.

Salpingectomy does not appear to compromise the rate of subsequent intrauterine pregnancy in women whose contralateral fallopian tube appears to be normal and avoids the complication of persistent or recurrent ectopic pregnancy in the same tube². The rate of persistent ectopic pregnancy after conservative surgery ranges from 3% - 20%. Moreover, recurrent ectopic pregnancy rates are 15.4% after linear salpingostomy, compared with 9.8% after partial or total salpingectomy, and 8% after single-dose methotrexate³. The recurrence risk rises to 30% following two ectopic pregnancies⁴.

Adelusi et al reported a case of a woman with three consecutive recurrent ectopic pregnancies who had laparotomy with conservative evacuation of conceptus from the tube on two occasions and conservative removal of an unruptured left ampullary ectopic pregnancy to preserve the patency of the tube. Unfortunately, only right tubal patency could be confirmed as patient was lost to follow up. In this case, conservative management of the tubes to retain tubal patency was successful as the woman was able to conceive, recurrent ectopic pregnancies, however, may damage the tubes⁵.

Salpingotomy is recommended in women who are hemodynamically stable and appear to have a reasonable probability of future normal function in the affected tube. However, salpingectomy is performed instead in situations of recurrent ectopic pregnancy in the same tube, severely damaged tube, uncontrolled bleeding from implantation site

or in women who have completed their family or those are who will be treated by in vitro fertilisation. This is due to low probability of normal tubal function and high risk of persistent or recurrent tubal ectopic pregnancy⁶.

In conclusion, there is a dilemma in managing patients with recurrent ectopic pregnancies treated medically or surgically due to increased risk of recurrence. There are also profound emotional and psychological problems with these patients which need to be addressed particularly if they are nulliparous with a desire for future pregnancy. Perhaps, bilateral salpingectomy and referral for IVF in women with recurrent ectopic affecting both tubes and those with severely damaged tubes should be recommended. This was the view shared by Tulandi who recommended referral for IVF if a woman does not conceive in the first 12 - 18 months after surgical therapy of ectopic pregnancy or her contralateral tube is damaged or absent⁶. ■

Conflict of interest

All authors declare no conflict of interest.

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