Ovarian Pregnancy

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Abstracts: Primary ovarian pregnancy is a rare type of extra-uterine pregnancy, and occurs in 1:7000 to 1: 40,000 deliveries. This is a case that occurred in a 26 years old multiparous woman. She had presented with pain abdomen and bleeding per vaginum and was hemodynamically stable, negative pregnancy test, but vaginal examination showed painful cervical movements, slight bleeding through external os, uterus just bulky, tender mass felt in right adnexa. Ultrasonography revealed—Right tubo-ovarian mass with fluid in peritoneal cavity. Laparotomy showed Right Ovarian Pregnancy. Managed by Right Ovariectomy. [Swami M NJIRM 2014; 5(4) :128-130]

Key Words: Ectopic ovarian pregnancy, ovarian pregnancy.

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Introduction: Ovarian pregnancy is known to be rare type of extra-uterine pregnancy. As per Indian literature, its incidence varies from 0.001% to o.o13% of normal pregnancies. And from 0.17% to 1% of ectopic pregnancies.1:7000 to 1: 40,000 deliveries. 15 % ovarian pregnancies are intra-follicular in origin in which a well preserved corpus luteum can be identified in the wall of gestational sac. Remaining ovarian pregnancies are extra-follicular. Spiegelberg's criteria (1878)Diagnostic criteria for ovarian pregnancy are (1) Tube of affected side must be intact, (2) Gestational sac must be in position of ovary, (3) Gestational sac must be connected to uterus by ovarian ligament (4) Ovarian tissue must be present in the sac wall on histological examination.

Case report: A 26 year old woman was admitted on 4th Jan 2010 at R D Gardi Medical College with complaints of pain in abdomen more marked in right iliac fossa from last 8 days. She had bleeding per vagina from 5 days. She was para 2, live issues 2, Abortion 0. Prior to her present vaginal bleeding her menses was normal. Tubectomy was done 5 years ago. She was not pale, pulse was 88/min regular, Blood pressure was 110/80 mm Hg, Respiration 20/min. chest was clear, cardiovascular system was normal. Abdominal examination revealed tenderness in lower abdomen on right side, no distension & no mass. Vaginal examination showed painful cervical movements, slight bleeding through external os, uterus just bulky, deviated to left side, tender mass felt in right adnexal region through right fornix. Her hemoglobin was 9.8gm/dL , Blood group A Rh positive, Urine pregnancy test was negative. Colpocentesis test was negative. Ultrasonography revealed—Right tubo-ovarian mass with fluid in peritoneal cavity. Diagnostic laparoscopy fallowed by laparotomy done under intra-tracheal anaesthesia. Laparotomy showed hemoperitoneum and normal looking tubes. Left ovary was normal looking but right ovary was enlarged and occupied with blood clots and placental tissue indicating ruptured ectopic pregnancy. There was active bleeding from ovarian surface. Right ovary with ruptured pregnancy and normal right tube removed. About 200 ml blood & blood clot removed. Peritoneal toileting done. Abdomen closed. Post operative period was uneventful and she was discharged on 7th day and advised to come for fallow up.

Histology showed normal ovarian tissue , sheet of decidual cells , blood clots , and placental tissue. This confirmed the diagnosis of right sided ovarian pregnancy.

Figure 1

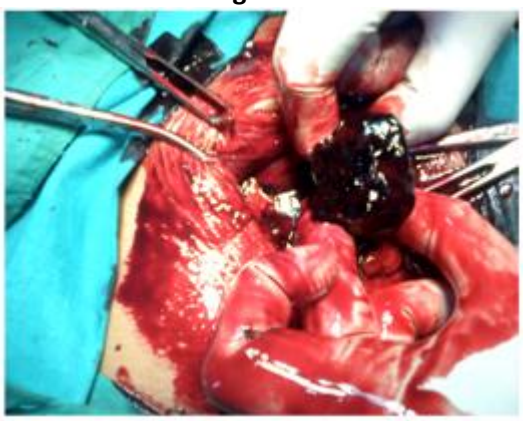


Figure 2

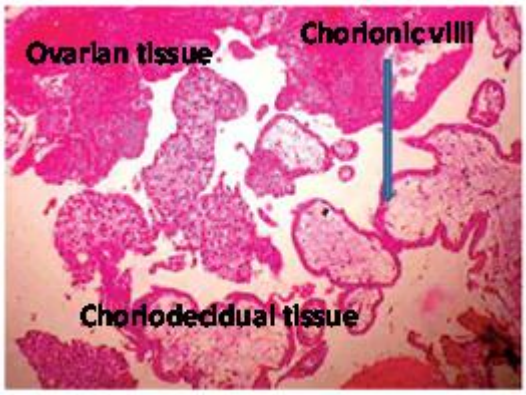


Figure 3

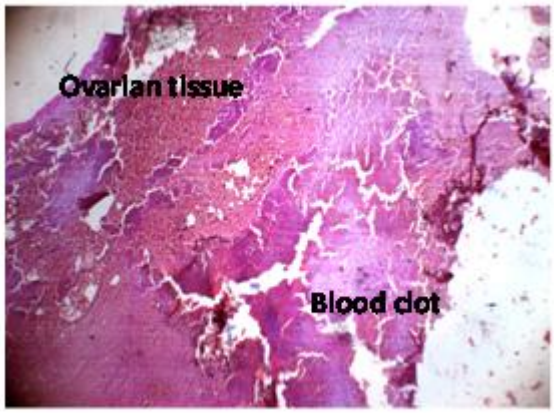
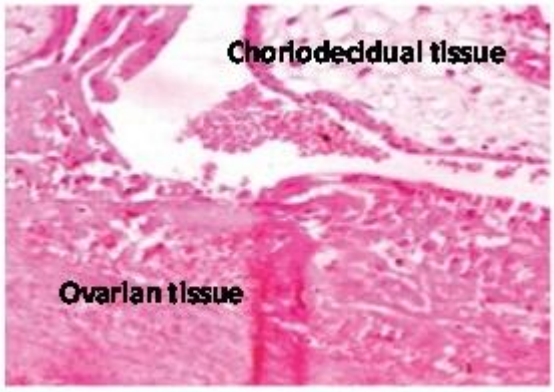


Figure 4



Discussion: Ovarian pregnancies are dangerous and prone to develop internal bleeding. Thus, when suspected, intervention is called for. Risk factor associated with ovarian pregnancy remains same as with other site of ectopic pregnancy. Incidence reported is more with IUCD users, but ovarian pregnancy can also occur in post-tubectomy cases. The presence of endometrial rests or endometrioma of the ovary has been suggested to favor the occurrence. Before laparotomy, diagnosis of ovarian pregnancy is most difficult of all extrauterine pregnancies. Chronic pelvic pain alone, a symptom not always easily related to its cause, is the most frequent clinical manifestation of an ovarian gestation, whereas classic symptoms of tubal gestation are amenorrhea, vaginal bleeding & pain in abdomen. Palpable adnexal mass a most frequent finding, of ovarian gestation is usually confused with corpus leutial hematoma. Even though ovary can accommodate itself more readily than tube to the expanding pregnancy, rupture at early gestational period is usually seen. There is recorded case of ovarian pregnancy reaching up to term. Clinically all the criteria useful for diagnosis of tubal pregnancy are helpful in diagnosing a primary ovarian pregnancy. In Laparotomy findings, Spingelberg's criteria are used to confirm ovarian pregnancy. Classical management of ovarian pregnancy is surgical. Early small lesion can be managed by ovarian wedge resection or enucleating of gestational sac, but large lesion require Ovariectomy. Recent advances in the management of ovarian pregnancy are laparoscopic laser ablation and Methotrexate for unruptured ovarian pregnancies.

Conclusion: Ovarian pregnancy is rare type of ectopic pregnancy. The diagnosis of ovarian pregnancy is difficult, thus, it continues to challenge the practicing clinicians. Clinically difficult to differentiate from ruptured tubal pregnancy , ruptured hemorrhagic corpus luteum and chocolate cyst. Diagnosis is clear only after laparoscopy / laparotomy findings and is confirmed after histopathology report.

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