Gael et al., J Clin Case Rep 2018, 8:6
DOI: 10.4172/2165-7920.10001127

Journal of Clinical Case Reports

Case Report Open Access

Bilateral Ruptured Ectopic Pregnancies with Massive Hemo-Peritonium: A Case Report in a Resource-Low Setting in Sub-Saharan Africa

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Abstract

Background: Bilateral ruptured ectopic pregnancy is the rupture of two implanted product of conception outside of the uterine cavity. Bilateral ruptured ectopic pregnancy without an initial induction of ovulation is extremely rare. It's occurrence with a major life threatening complication such as massive hemo-peritonium worsens the prognosis. Immediate diagnosis and surgical intervention is required. Few cases have been identified.

Case report: We report the case of bilateral ruptured ectopic pregnancy with massive hemo-peritonium diagnosed in a 28-year- old female and managed at African Genesis Health Clinic Yaoundé.

Discussion and Conclusion: prompt diagnosis and surgical intervention is needed to improve the prognosis related to bilateral ruptured ectopic pregnancies with massive hemo-peritonium. Counseling for assisted means of procreation is important.

Keywords: Bilateral tubal pregnancy; Ruptured ectopic pregnancy; Massif hemo-peritonium; CMC African genesis health

Introduction

Bilateral ruptured ectopic pregnancy is the rupture of two implanted product of conception outside of the uterine cavity [1]. The incidence of simultaneous bilateral tubal pregnancies ranges from 0.63 to 1.38 per thousand [2]. The risk factors for ectopic pregnancy includes early age of sexual intercourse, increased maternal age, multiple sexual partners, pelvic infections, history of infertility, use of fertility drugs, previous ectopic pregnancies and previous pelvic surgeries [3]. This report describes the case of bilateral ruptured ectopic pregnancy with massive hemo-peritonium diagnosed in a 28-year-old female and managed at African Genesis Health Clinic Yaoundé.

Case Report

A 28-year-old female who presented with 6weeks amenorrhea, vaginal spottings and an initial left unilateral pelvic pain which subsequently become bilateral 3 days prior to consultation. The past history was relevant for chlamydia infection in 2015 for which the pateint refuse treatment; multiple sexual partners; no intra-uterine device usage; has never been operated upon (no tubopasty nor ligation); no history of ectopic pregnancy. There was nausea, vomiting, generalise fatigue, dizziness, no fever, no frequency and no dysuria. On examination the pateint is drowsy, oxygene saturation (67%), BP (64/42 mmHg) and respiratory rate (38 cycles/min). The pulse was faint rapid and tredy(120 beats/min). The conjunctivae were pale, sclere anicteric. Breath sound was vesicular. There was a gallop rythme. Abdomen was distended (abdominal circumference 104 cm) with signs of peritoneal irritation. Vaginal examination was relevant for a tender chandelier sign and bilateral adnexal tenderness. Digital rectal examination reveiled a tender douglas pouch. The diagnosis of hemorrhagic shock with a probable etiology of left ruptured ectopic pregnancy was made with differentials of hemorrhagic ovarian cyst. The results of the investigations where as follows: abdomino-pelvic ultrasound showing a right ruptured ectopic pregnancy with massive hemo-peritonium, erect plain abdominal x-ray shows no sign bowel perforation, FBC (Hb 6.3g/dl; moderate normocytic normochromic anemianormal leucocyte and platelets count), PT (27sec), APTT (32 sec), BUN (22 mg/dl), Creatinine(1.0 mg/dl), serum electrolyte (Na^+: 133 mEq/L, K^+: 3.6 mEq/L), Blood group/rhesus(A/+). Working diagnosis: hemorrhagic shock with etiology right ruptured ectopic pregnancy with massive hemo-peritonium. The management consisted of: pre-operatory work-up and pre-anesthetist evaluation, obstetritians reassessment and transfusion of 2 pints of pack cells pre and per-operatory. The surgical intervention in Figure 1 consisted of a laparotomy from a fannesteil incision, bilateral antegrade salpingectomy, peritoneal lavage and closure.

On post-operatory day 1, the patient was transfused the 3rd pint of whole blood. On post-operatory day 5 repeat full blood count revealed a hemoglobine level of 8.8 g/dl. The patient was discharged and followed up on weekly bases. There was no post-operatory complication.

Discussion

Bilateral ruptured tubal ectopic pregnancies are a rare condition causing a high maternal mortality and morbidity. The incidence of simultaneous bilateral tubal pregnancies ranges from 0.63 to 1.38 per thousand [2]. The causes of bilateral ectopic pregnancies could be: simultaneous multiple ovulation, sequential impregnation or trans-peritoneal migration of trophoblastic cells from one extra-uterine pregnancy to the other tube. Recurrent ectopic pregnancies occur in 6% to 16% of women with previous history of ectopic pregnancy referred by

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Received June 03, 2018; **Accepted** June 05, 2018; **Published** June 08, 2018

Citation: Gael D, Bienvenu BH, Francois DMC, Fabrice SD, Stephane KMW, et al. (2018) Bilateral Ruptured Ectopic Pregnancies with Massive Hemo-Peritonium: A Case Report in a Resource-Low Setting in Sub-Saharan Africa. J Clin Case Rep 8: 1127. doi: 10.4172/2165-7920.10001127

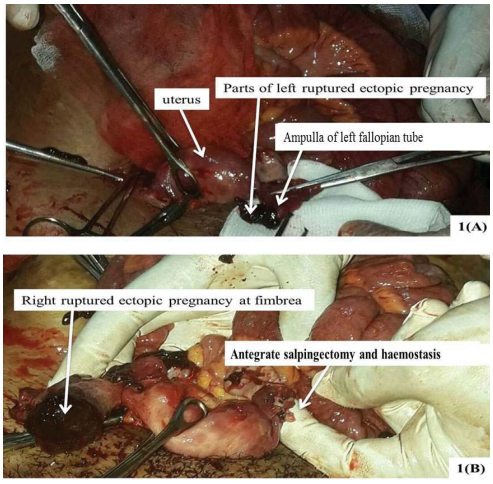

Figure 1: Bilateral ruptured ectopic pregnancy **(A)** right ruptured ectopic pregnancy at ampulla. **(B)** left ruptured ectopic pregnancy at fimbrea.

Igwegbe, Eleje, Okpala [3] and many women, for unknown reasons, fail to conceive even after successful reconstructive tubal surgery [4,5]. The Diagnosis is clinical but ultrasound is needed to confirm the diagnosis. The management of bilateral ruptured tubal ectopic pregnancies with massive hemo-peritonium is an emergency requiring a holistic approach. Despite the uncontrolled nature of the haemorrhage on the right tube and the damage of the left tube we proceeded with a bilateral antegrade salpingectomy.

Conclusion

Though relatively rare, the authors describe their experience in the management of this very important cause bilateral ruptured ectopic pregnancy with massive hemo-peritonium. Prompt diagnosis and surgical intervention is needed to curb the morbidity and mortality of this disorder.

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