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Clinical Daignosis Of Tubal Ectopic Pregnancy

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ABSTRACT-

Implantation of zygote in a site other than the uterine cavity occurs in 2% of pregnancy .The incidence of ectopic pregnancy increase significantly in the past centuries. The diagnosis of ectopic pregnancy is complicated by the wide spectrum of clinical presentation from asymptomatic cases to acute abdomen and hemodynamic shock. The diagnosis of ectopic pregnancy is based on combination of measurement of serum quantative human chronic gonadotropin (hcG) and finding on trans vaginal ultra sonography (TVUSG). The clinical manifestation and diagnosis of ectopic pregnancy will be reviewed here. This will focus mainly on diagnosis of tubal pregnancy .

INTRODUCTION –

An ectopic or extrauterine pregnancy is defined as pregnancy implanted outside the uterine cavity with 98% implanting in the fallopian tube. In the developing world, the incidence is much higher 1 in 10 women admitted with the diagnosis of tubal ectopic pregnancy ultimately die from the condition. The incidence varies from place to place even in the same country ,One of the determining factors being the frequency of pelvic infection – gonococcal, post abortal ,puerperal or tuberculosis in any pregnancy.

Detection of ectopic pregnancy in early gestation has been achieved mainly due to enhanced diagnostic capability. Despite all these notable success in diagnostic and detection techniques ectopic pregnancy remains a source of serious maternal morbidity and mortality world wide , especially in countries with poor prenatal care. In the condition of lack of diagnostic

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facilities there is a necessity of clinical diagnosis to rule out the condition of ectopic pregnancy.

SITES OF ECTOPIC PREGNANCY¹-

The possible sites from above downwards are : abdominal cavity, fallopian tube, broad ligament, rudimentary horn of bicornuate uterus and cervix. By far the commonest is fallopian tube when twinning occurs there may be simultaneous intrauterine and extrauterine pregnancies and simultaneous bilateral tubal pregnancies. The ovum implants in one of the four main positions of tube 1) fimbriated opening – a primary implantation at this site is unusual 2) ampulla – this is the commonest and least dangerous site. 3)isthmus – this is the least commonest and more dangerous because of the likelihood of tubal rupture. 4)interstitial- the site in 3% of all tubal pregnancies.

RISK FACTORS FOR ECTOPIC PREGNANCY- (ETIOLOGY)¹ –

An appearance for risk factor for ectopic pregnancy may lead to a more timely diagnosis tubal pathology , surgery to restore tubal patency or tubal sterilization carry the highest risk of obstruction and subsequent ectopic pregnancy. A women with prior ectopic pregnancies has a 10 fold chances for another.

A) Abnormalities of the tube impeding the progress of the fertilized ovum:

1. Developmental errors – errors such as hypoplasia , diverticuli , an accessory lumina .
2. Distortion of the tube – the fallopian tube may be distorted by a large tumours or endometriosis , infection, peritubal adhesions , partial closure of lumen and disturbed tubal functions .
3. Surgical obstruction – The fertilized ovum sometimes implants on the stump of tube after partial salpingectomy.
4. Tubal surgery- This is likely to be increasing cause because of increase in microsurgery and reversal of sterilization .
5. Intrauterine contraceptive device – It is suggested that the incidence of ectopic pregnancy is higher because IUCDs prevent intrauterine pregnancies .

B) Over development of the ovum –

Its early development has proceed to such an extend that it may be too big to pass the isthmic portion of tube or more important it has acquired its trophoblast which encourage its implantation before it reaches the uterus.

C) Endometriosis of the fallopian tube -

This cause is difficult to prove but it is suggested that patchy differentiation of the endosalpinx

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into endometrium encourage premature embedding of the ovum.

presence of free blood in the peritoneal cavity may be indicated by dullness in the flanks and intestinal distention in front.

SIGNS AND SYMPTOMS² –

Tubal pregnancy present as a chronic or an acute illness or as an chronic on acute. Clinically three distinct types are described²-

- 1) Acute.
- 2) Unruptured.
- 3) Sub acute or chronic or old.

Vaginal examinations should not be carried out for fear of precipitating more bleeding but if it is some enlargement of one appendages may be detected. Acute tenderness and the production of pain by movement of cervix are the leading signs.

ACUTE ECTOPIC -

This is seen when there is a sudden massive intraperitoneal haemorrhage and is typical of tubal rupture rather than tubal abortion. After a short period of amenorrhoea and sometimes none, The patient is seized with a severe lancinating pain in one iliac fossa or in hypogastrium. This is immediately followed by profound collapse marked by pallor, low blood pressure, sub normal temperature and a weak rapid pulse. feeling of nausea, vomiting, fainting attacks even to the extent of syncope may be present. The syncopal attacks is peculiar to ectopic and is probably due to reflex vasomotor disturbance caused by irritation to the peritoneum by the blood.

CHRONIC OR OLD ECTOPIC- This is seen when intraperitoneal bleeding from the tube is small in amount but recurrent as in the tubal abortion and tubal mole. The patient has a short period of amenorrhoea and sometimes notices other symptoms of early pregnancy such as nausea and breast pains. Distention or contractions of the tube may cause aching in one or other iliac fossa. This is not so noticeable, however as are attacks of sharp stabbing pain caused by choriodecidual haemorrhages or by escape of blood into the peritoneal cavity. The combination of pain and syncope is the most constant and characteristic symptom of ectopic pregnancy. When the patient lies down the blood tracks to the diaphragm and this is manifested by shoulder tip pain or by epigastric pain which is worse on inspiration.

Examination reveals obvious signs of shock and anaemia. the patient lies quiet and conscious, perspires and looks blanched. Pallor is usually severe and depends on the amount of internal haemorrhage. The lower abdomen is usually acutely tender. The

Slight vaginal bleeding follows lower abdominal pain and this is easily mistaken for the late onset of menstrual period. once this bleeding has begun it tends to continue (if only as a brown discharge) without intermission this is a diagnostic feature. A

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decidual cast may be recognized in the discharge.

Examination reveals tenderness and muscle guarding over the lower abdomen, especially on the affected side is a striking feature. Degree of intestinal distention is a common and important diagnostic sign. haemoperitoneum of 2-3 wks standing can cause the appearance of bruising around the umbilicus (cullen's sign). Vaginal examination include an irregular and tender enlargement of the appendages on the affected side and an ill defined tender semi solid swelling in the pouch of douglas indicative of pelvic haematoma. Tenderness in pelvis is most constant sign.

UNRUPTURED TUBAL ECTOPIC-

High degree of suspicion and an ectopic conscious clinician can only diagnosis the entity and its prerule state. It is often diagnosed accidentally during laproscopy and laprotomy. The physician should include ectopic in differential diagnosis when sexually active female has abnormal bleeding and abdominal pain.

Presence of delayed periods or spotting with features suggesting pregnancy, uneasiness on one side of flank which is or at times colicky in nature.

A pulsatile small well circumscribed tender mass may be felt through one fornix separated from uterus. The palpation should be gentle else rupture may precipitate and

massive intra peritoneal hemorrhage with shock and collapse may occur dramatically.

DIFFERENTIAL DAIGNOSIS¹-

- 1) Abortion of early intrauterine pregnancy – In this condition the initial period of amenorrhoea tends to be longer and uterine bleeding nearly always precedes and over shadows pain. Persistence of uterine bleeding and abdominal pain after curettage for supposed incomplete abortion is often the clue to diagnosis of ectopic pregnancy.
- 2) Early intrauterine pregnancy complicated by pelvic tumour-tumours such as fibroids, ovarian cyst and the second horn of bicornuate uterus may be confused with ectopic pregnancy.
- 3) Retroverted gravida uterus- A haematocele producing a cystic swelling in the pouch of douglas which lifts the cervix upwards and forward and causes retention of urine is easily mistaken for impacted retroverted gravid uterus with threatened abortion.
- 4) Acute or subacute salpingitis (including tuberculosis)- conclusion arises here because of the late onset of menstrual period followed by irregular uterine bleeding, the finding of tenderness and appendages. Salpingitis is a bilateral condition and is unlikely to cause fainting and collapse.

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- 5) Dysmenorrhoea – ectopic pregnancy can be dismissed by the patient as well as others as late painful menstrual periods. However in ectopic the pain is unilateral and fainting, the bleeding is atypical in amount and duration.
- 6) Rupture of an endometriotic cyst-here the sudden onset of pain and collapse, signs of peritonism and finding of an appendage swelling are confusing. The rupture usually occurs during menstruation.
- 7) Torsion of an ovarian cyst or pedunculated fibroid-distinguishing feature are the menstrual history and the presence of fainting.
- 8) Intra peritoneal haemorrhage- the real confusion is bleeding from the corpus luteum of an early intrauterine pregnancy. In such cases absence of uterine haemorrhage is in favour of corpus luteum haematoma, but it may be impossible to distinguish this condition from ectopic pregnancy without laprotomy.
- 9) Acute appendicitis –in this disease menstrual disturbance and fainting are absent, vomiting more likely. The patient is flushed rather than pale.

Abdominal rigidity is more pronounced.

- 10) Perforated peptic ulcer – this causes pain in upper rather than lower abdomen and more rigidity of abdominal wall. Vomiting is common and fainting unusual.

CONCLUSIONS :- Current evidence supports that the tubal ectopic pregnancy can be diagnosed clinically.

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