

Bilateral tubal ectopic pregnancy with live right ampullary gestation and contralateral occult tubal ectopic pregnancy: A rare case report

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ABSTRACT

Bilateral tubal ectopic pregnancy is an exceptionally rare form of ectopic gestation, with an estimated incidence of approximately 1 in 200,000 pregnancies. Diagnosis is often challenging because clinical and radiological findings usually identify only one ectopic pregnancy preoperatively, whereas the contralateral lesion remains undetected until surgery. We report a case of a 25-year-old female, G3P1L1A1, who presented at 6 weeks 2 days of gestation with abdominal pain and vaginal bleeding. Ultrasonography revealed a live right tubal ectopic pregnancy with fetal cardiac activity. Laparoscopic evaluation demonstrated a right ampullary ectopic pregnancy with active bleeding through the fimbrial end and an unexpectedly dilated left fallopian tube suspicious for concomitant ectopic gestation. Bilateral salpingectomy was performed. Histopathological examination confirmed bilateral tubal ectopic pregnancy with associated hydrosalpinx of the left tube. This case highlights the importance of meticulous inspection of both adnexa during surgical management of ectopic pregnancy.

Key words: Ampullary pregnancy, Bilateral tubal ectopic pregnancy, Ectopic pregnancy, Hydrosalpinx, Laparoscopic salpingectomy

Ectopic pregnancy refers to the implantation of a fertilized ovum outside the uterine cavity and remains a significant cause of first-trimester maternal morbidity and mortality [1]. More than 95% of ectopic pregnancies occur within the fallopian tubes, most commonly in the ampullary region [2]. Bilateral tubal ectopic pregnancy is extremely uncommon. The incidence of spontaneous bilateral ectopic pregnancy is approximately 1 in 725 pregnancies and 1 in 1580 ectopic pregnancies [3,4]. The diagnosis is particularly difficult because ultrasonography typically identifies only one ectopic gestation. Consequently, most cases are diagnosed intraoperatively or following histopathological examination [5,6]. Early recognition and prompt surgical management are essential to prevent tubal rupture, massive hemorrhage, maternal mortality, and the need for repeat surgery.

CASE REPORT

A 25-year-old female, G3P1L1A1, presented to the obstetrics and gynecology outpatient department with complaints of amenorrhea for 1.5 months and lower

abdominal pain for 4 days associated with bleeding per vaginam for 1 day.

On examination, the patient was hemodynamically stable. Abdominal examination revealed mild lower abdominal tenderness without guarding or rigidity. Per vaginal examination demonstrated cervical motion tenderness and fullness in the right adnexal region.

Routine laboratory investigations were within normal limits except for an elevated serum β -hCG level >5000 mIU/mL. Transvaginal ultrasonography revealed a single live extrauterine tubal pregnancy with a crown-rump length of 4.0 mm, corresponding to a gestational age of 5.6 weeks, and fetal cardiac activity of 118 beats per minute, associated with a bagel sign and ring-of-fire appearance. No intrauterine gestational sac was visualized. Findings were suggestive of a right-sided tubal ectopic pregnancy (Fig. 1).

Considering the presence of a live tubal ectopic pregnancy, the patient was planned for emergency laparoscopic management. Intraoperatively, a right ampullary ectopic pregnancy was identified with active bleeding through the fimbrial end, and the right fallopian tube appeared distended and congested. During systematic inspection of the contralateral adnexa, the left fallopian tube was markedly dilated (approximately

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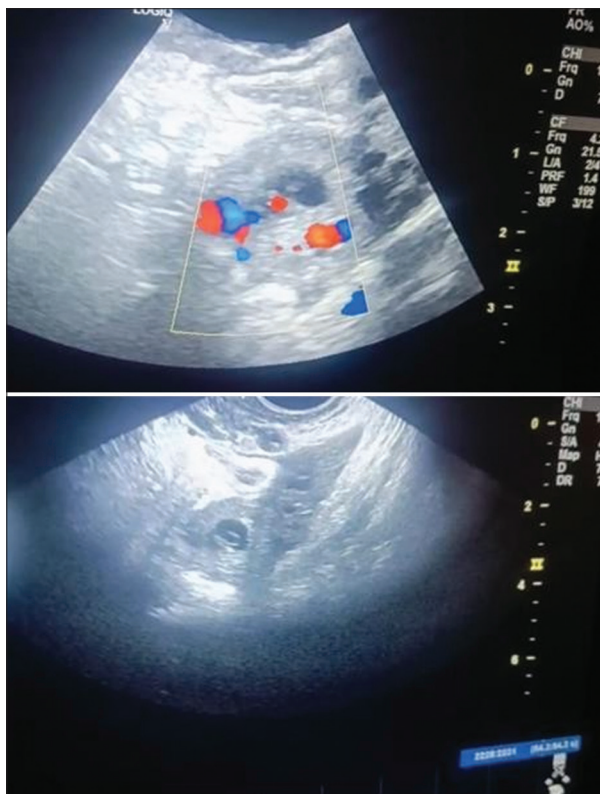


Figure 1: Transvaginal ultrasonography showing the bagel sign and ring-of-fire appearance

3–4 cm) with bluish discoloration of its mid-portion. This abnormal appearance raised suspicion of a concomitant left tubal ectopic pregnancy, although hydrosalpinx was also considered. Thus, a bilateral tubal ectopic pregnancy was suspected intraoperatively (Fig. 2).

Histopathological examination confirmed the presence of chorionic villi and trophoblastic tissue within both fallopian tubes, establishing the diagnosis of bilateral tubal ectopic pregnancy. The left tube additionally demonstrated features consistent with hydrosalpinx.

The post-operative period was uneventful, and the patient was discharged in stable condition with appropriate follow-up advice.

DISCUSSION

Spontaneous bilateral tubal ectopic pregnancy is one of the rarest forms of ectopic gestation. Most reported cases have been associated with assisted reproductive techniques, ovulation induction, or pelvic inflammatory disease; β -hCG levels and the discriminatory zone are not reliable when the pregnancy is bilateral.

Clinical presentation is similar to that of unilateral ectopic pregnancy and typically includes abdominal pain, amenorrhea, and vaginal bleeding [3]. Pre-operative diagnosis remains challenging because ultrasonography usually detects only one ectopic pregnancy, as occurred in the present case [7].

The mechanism underlying bilateral tubal ectopic pregnancy remains unclear. Proposed theories include

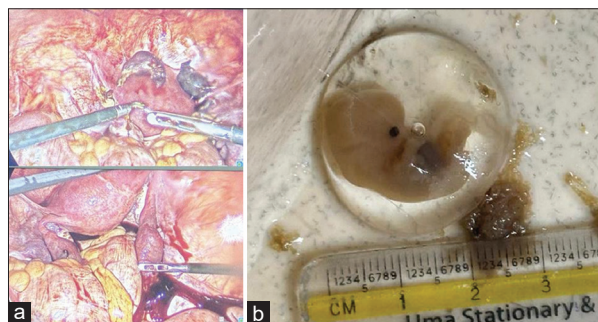


Figure 2: (a) Intraoperative bilateral swollen fallopian tubes; (b) Live ectopic pregnancy with intact gestational sac

multiple ovulation, implantation at the site of tubal damage, transperitoneal migration of trophoblastic cells, and simultaneous implantation of two embryos within separate tubes [8,9].

Laparoscopy remains the gold standard for diagnosis and management. During surgery, careful inspection of both fallopian tubes is mandatory because failure to identify a contralateral ectopic pregnancy may result in persistent trophoblastic disease and recurrent symptoms [2,6]. There are no case reports of successful medical management with methotrexate in bilateral tubal pregnancy.

Histopathological confirmation demonstrating chorionic villi within both tubes is essential for definitive diagnosis [10]. In our patient, the diagnosis was established only after histopathological examination despite intraoperative suspicion of a contralateral lesion.

This case emphasizes the importance of maintaining a high index of suspicion for bilateral ectopic pregnancy even when imaging identifies only a unilateral ectopic gestation.

CONCLUSION

Bilateral tubal ectopic pregnancy is a rare but potentially life-threatening condition. Pre-operative diagnosis is difficult because imaging studies frequently identify only one ectopic pregnancy. Thorough laparoscopic examination of both adnexa and histopathological confirmation are crucial for accurate diagnosis. Early surgical intervention can prevent catastrophic complications and improve maternal outcomes.

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