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ECTOPIC PREGNANCY FOLLOWING TUBAL STERILIZATION SURGERY

TUBAL STERILIZATION SURGERY

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ABSTRACT

Ectopic pregnancy represents an important cause of maternal morbidity and mortality, with an incidence that has dramatically increased in recent years. Tubal sterilization has become an important cause of ectopic gestation because of the growing number of elective sterilizations currently performed (1.2). This report describes a case of ectopic gestation following tubal sterilization surgery.

CASE REPORT

A 29 years old, para VI-1, abortus 0, was seen in Jimma hospital with complaints of left lower quadrant pain of one week and vaginal spotting of two days duration. The patient had a normal obstetric history. Four years ago, she had caesarean section for antepartum hemorrhage, at Metu hospital, at which time tuba ligation was also performed. The type of tubal ligation was not known. The patient's last normal menstrual period occurred seven weeks prior to admission. There has been scanty staining for two days prior to admission.

On examination, the patient's vital signs were stable she appeared to be in no acute distress. The abdomen was soft and there was tenderness on deep palpation in the left lower quadrant. There was no guarding and no rebound tenderness.

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On pelvic examination, the external genitalia demonstrated no abnormality. The cervix was closed. It was tender on motion, the cul-de-sac felt empty. The adnexae were tender bilaterally, more so on the left. There was no mass and the uterus was normal size. Urinalysis demonstrated no abnormality, Hemoglobin was measured at 10 gm/dl. Culdocentesis revealed darkish, non-clotting blood because of the strong suspicion of ruptured ectopic pregnancy, Laparotomy was performed. A ruptured ectopic gestation was found in the distal tubal stump on the left side. There was 200 ml of free blood in the peritoneal cavity. Left Salpingo Ophorectomy and re-ligation of the contra lateral fallopian tube were performed. The patient had an uncomplicated post operative course.

DISCUSSION

In our institution, ectopic pregnancy is a relatively common gynecologic problem. However, this is the first case report of ectopic pregnancy following tubal sterilization surgery. An the incidence of 7% of 100 consecutive ectopic pregnancies, the highest reported, indicates that prior sterilization is increasing in importance as a cause of ectopic pregnancy (2). Breen (3) in 1970 surveyed 654 cases of ectopic pregnancy and found only 4 women who had a previous tubal ligation (0.6%). In 1973 Harralson et al (4) reported an incidence of 5.2% of ectopic pregnancy following bilateral tubal sterilization surgery. Prinary tubal sterilization has been associated with a failure rate of 0.7 % (5). of those pregnancies following tubal sterilization 5-12 % will be ectopic gestations. The etiology of tubal pregnancy after tubal sterilization includes those of ectopic gestations in general. Several mechanisms unique to tubal implantation after tubal sterilization have been proposed.

Recanalization of the fallopian tube with formation of a narrow lumen large enough to permit the passage of the small spermatozoa but not the much larger fertilized ovum represents the most widely accepted mechanism. (6)

Recanalization may also be associated with an irregular tubal architecture that does not permit normal ovum transport. The formation of tubo- peritoneal fistulas in the proximal tubal stump has also been suggested. Presumably such pregnancies result from transperitoneal migration of sperm from a fistula in the proximal stump of one or another of the ligated tubes (7).

The maternal mortality from ectopic pregnancy is considerable and it is related either to unnecessary delay or to failure to establish the correct diagnosis. Ectopic pregnancy must be part of the differential diagnosis whenever a woman reproductive age develops lower abdominal pain and/or abnormal uterine bleeding. The diagnosis of ectopic pregnancy should not be excluded because of patient's past history of bilateral tubal ligation