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RISING NUMBER OF ECTOPIC PREGNANCIES PRESENTING AT TERTIARY CARE HOSPITALS

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Abstract:
Objective: *The purpose of this study was the determine the clinical presentation, treatment, risk factors, mortality and morbidity related to ectopic pregnancy.*
Material and Methods: *This study was conducted at Allied Hospital Faisalabad and the duration of this study was from 01-01-2014 to 01-01-2015 on the sample of 80 patients analyzed through clinical features, operative outcomes, modality of treatment and risk factors.*
Results: *Against 2645 delivery cases hospital admission was made in 80 cases as 3% of the total delivery cases. The age group of the maximum number of cases was 25 – 29 years (43.75%) with gravida cases as (41.25%), identified risk factor in (66.25%) cases as the abortion was not common previously as a risk factor (31.25%). Amenorrhea classical triad, vaginal bleeding and abdomen pain abdomen was observed in (71.25%) cases, ruptures tubal pregnancy (55%), unruptured tubal pregnancy (10%) and one bilateral ectopic pregnancy case. Mainstay treatment method was applied for Salpingectomy (86.25%).*
Conclusions: *One of the major challenges in the pregnancies is an ectopic pregnancy. Mostly our country is observed with tubal rupture which requires an essential treatment through surgical methods. Maternal morbidity and fertility future can be saved through an early diagnosis, treatment and surgery.*
Keywords: *Ectopic, Morbidity, Pregnancies, Salpingectomy, Hemoperitoneum.*

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INTRODUCTION:

Ectopic pregnancy can be referred to an extra or intra-uterine pregnancy where a fertilized ovum implants at abnormal site that is in conducive in development and growth. In the 2% pregnant cases it is a threat to life of the patient and common 1st trimester mortality cause, which makes the ectopic pregnancy a serious issue of the modern practice and a challenge to the obstetricians with increased incidence of suspicion in the vaginal bleeding, abdominal pain and triad of amenorrhea. There is presence of non-specific sign in the women such as non-awareness of the pregnancy and presence of a hemodynamic shock [1]. An early diagnosis can manage the unruptured ectopic pregnancy with success. Fatality is decreasing because of an early diagnosis. Most of the cases till rupture considered as asymptomatic as its 97% occurrence is in fallopian tubes. No risk factors are observed in frequent pregnancies, which have been reflected through controlled and prospective research about the increased awareness and risk factors related to the incidence of ectopic pregnancy; risk factors include pelvic inflammatory disease, ectopic pregnancy history, abdominal surgery, pelvic surgery and tubal sterilization that help in the early diagnosis [2]. Clinical presentations are very vital in this regard, ectopic site and future re-productivity requirements, its management can be both surgical or medical.

MATERIAL AND METHODS:

This study was conducted at allied hospital Faisalabad and the duration of this study was from 01-01-2014 to 01-01-2015 at Allied Hospital Faisalabad. 80 patients analyzed through clinical features, operative outcomes, modality of treatment and risk factors. Diagnosis was made through historical presence, physical and clinical examination, radiological and laboratory investigations. We considered the record kept in the registers of gynecology, causality, operation theaters, labor rooms and wards for the total deliveries carried out in the time span of our research. We also made an analysis of the demographical data of the patients and studies the available record and information of the amenorrhea period, diagnosis time, complain of abdomen pain, vaginal bleeding and acute abdomen pain [3]. at the time of diagnosis, presenting complaints like pain abdomen, bleeding per vagina and risk factors predisposition. UPT (Urine Pregnancy Test) was also carried out along with ultrasound. We also studied available management and treatment options and documented all the information on a pre-designed Performa through percentages. Our research included every woman presenting the confirm incidence of ectopic pregnancy in the research time period.

RESULTS:

Against 2645 delivery cases hospital admission was made in 80 cases as 3% (30/1000) of the total 2645 delivery cases.

Table-I: Distribution of Cases According to Age

Age	Percentage
< 20	1.25
20 - 24	20
25 - 29	43.75
30 - 34	26.25
35 - 39	3.75
> 40	5

We observed that maximum ectopic pregnancies (43.75%) occurred in the age of 25 – 29 years.

Table-II: Distribution of Cases According to Birth Order

Gravida	Number	Percentage
G1	15	18.75
G2	12	15
G3	20	25
> G4	33	41.25

Majority were above Gravida (41.25%) and the diagnosis was made in the week number from 6 – 8.

Table-III: Duration of Amenorrhea

Amenorrhea Duration	Percentage
Absent	13.75
< 6 Weeks	5
6 - 8 Weeks	72.5
> 8 Weeks	8.75

One or more than one risk factors were present in 66.25% cases. In the spontaneous or induced risk factors abortion rate was 31.25% and abdominopelvic surgery history in (23.75%) cases. Tubectomy was observed in (11.25%), LSCS in 11.25% and tuboplasty was observed in one patient. Self-administered MT Pill intake history was observed in (13.75%) cases. Repetition of ectopic pregnancies was observed in (3.75%) cases and no identification were observed in (33.75%) cases.

Table-IV: Distribution of Cases According to High Risk Factors

High Risk Factor	Number	Percentage
Previous abortion	25	31.25
MT Pill intake	11	13.75
Tubal ligation	9	11.25
LSCS	9	11.25
PID	8	10
infertility	5	6.25
Previous ectopic pregnancy	3	3.75
Tuboplasty	1	1.25
Ovulation Induction	1	1.25
IUCD	1	1.25
No risk factor identifiable	27	33.75

Abdominal pain classical triad, vaginal bleeding and amenorrhea were observed in (71.25%) cases.

DISCUSSION:

Ectopic pregnancy can be referred to an extra or intra-uterine pregnancy where a fertilized ovum implants at abnormal site that is in conducive in development and growth [4]. In the 2% pregnant cases it is a threat to life of the patient and common 1st trimester mortality cause, which makes the ectopic pregnancy a serious issue of the modern practice and a challenge to the obstetricians with increased incidence of suspicion in the vaginal bleeding, abdominal pain and triad of amenorrhea [5]. There is presence of non-specific sign in the women such as non-awareness of the pregnancy and presence of a hemodynamic shock. An early diagnosis can manage the unruptured ectopic pregnancy with success [6]. Fatality is decreasing because of an early diagnosis. Most if the cases till rupture considered as asymptomatic as its 97% occurrence is in fallopian tubes [7]. No risk factors are observed in frequent pregnancies, which have been reflected through controlled and prospective research about the increased awareness and risk factors related to the incidence of ectopic pregnancy [8]; risk factors include pelvic inflammatory disease, ectopic pregnancy history, abdominal surgery, pelvic surgery and tubal sterilization that help in the early diagnosis. Clinical presentations are very vital in this regard, ectopic site and future re-productivity requirements, its management can be both surgical or medical [9].

Pain and bleeding are the early markers of ectopic pregnancies and diagnosed at gestational age of 6 – 8 weeks. Our research observed, amenorrhea classical triad, vaginal bleeding and abdomen pain abdomen was observed in (71.25%) cases, ruptures tubal pregnancy (55%), unruptured tubal pregnancy (10%) and one bilateral ectopic pregnancy case [14]. Mainstay treatment method was applied for Salpingectomy (86.25%) which is also same as observed but few other authors present the incidence of abortion history as a risk factor involved in the tubal dysfunction and damage of the tube, awareness and education is required in order to improve abortion care and practice [6].

Every woman is to be suspected for the incidence of ectopic pregnancy having an abdominal pain, vaginal bleeding and amenorrhea whether with risk factors or without risk factors. Intra operative results were same as the USG results as observed in various research studies. The incidence of fallopian tube in observed as the repeated most ectopic pregnancy site (98.75%). Ampulla was also common as (42.5%), same as observed by the Shetty nearly (45.2%). Ovarian was observed in one case as (1.25%). Our research observed amenorrhea classical triad, vaginal bleeding and abdomen pain abdomen was observed in (71.25%) cases, ruptures tubal pregnancy (55%), unruptured tubal pregnancy (10%) and one bilateral ectopic pregnancy case. Mainstay treatment method was applied for Salpingectomy (86.25%); same has been observed by many of the other authors in their research studies. There was also an involvement of the left and right-side tube as found by Porwal and his colleagues [15]. Pre-operatively a case of bilateral ectopic pregnancy was also observed which forces the

examination of the tubes in the course of operation, even when there is a presence of adhesions for the diagnosis of the bilateral ectopic. We observed above 50% cases of ruptured ectopic pregnancies, which forces the early diagnosis for the better treatment of the disease. We also observed that most of the cases went through laparotomy as the presentation was unstable. Few research studies also reflected poor treatment as a result of poor laparoscopy expertise in the absence of supervisors as the result of an increased laparotomy. We observed in our research no case of mortality; whereas, maternal mortality is observed in the range of 0 – 1.3 % in numerous other research study. Fundamental clinical and surgical skills can control the rate of mortality.

CONCLUSION:

One of the major challenges in the pregnancies is an ectopic pregnancy. Mostly our country is observed with tubal rupture which requires an essential treatment through surgical methods. Maternal morbidity and fertility future can be saved through an early diagnosis, treatment and surgery. A delayed diagnosis leads to the increased chance of morbidity and also affects the fertility process. Awareness and safe practice of abortion is required in order to promote the cause and MTP use in the absence of supervision need discouragement.

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