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CASE REPORT

A case of left interstitial pregnancy after left adnexectomy – why surgical management?

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Interstitial pregnancy is a rare condition of tubal pregnancy with a mortality rate of 2–2,5% [4] that can easily be misdiagnosed. The prevalence of interstitial pregnancy is 0,8% in normal population and it increased during the past few decades due to reproduction techniques development even up to 11% in groups of women after in vitro fertilization. A comprehensive MEDLINE and OLDMEDLINE search covering years 1950–2005 using query terms "interstitial", "pregnancy" and "adnexectomy" identified only 10 cases reported in worldwide literature. The first treatment of interstitial pregnancy used to be a resection of the uterus body via laparotomy. Along with the evolution of sensitive biochemical assays, imaging technologies and the development of operative techniques, the management of interstitial pregnancy became less invasive.
We report a case of spontaneous left interstitial pregnancy after left adnexectomy due to left ovarian tumor of borderline malignancy.

Case Report

A 31-year-old, gravida 3, para 2, at 6 weeks gestation by last menstrual period suffered from left lower quadrant pain, mild cramping and vaginal spotting. Three months previously she had undergone laparoscopic left adnexectomy due to left ovarian tumor of borderline malignancy (cystadenoma papilare serosum) with an uneventful postoperative period. Initially a quantitive serum human chorionic gonadotropin level was 12942U/l. The pelvic examination included the nontender cervix and the nontender mobile uterus of normal size but in deep palpation a tumor 4 cm of diameter in the place of the left adnexa was diagnosed. The right adnexa were not palpable. The patient was normotensive. A transvaginal ultrasound examination (USG) revealed the body of the uterus in anteflexion of normal size and shape with the linear endometrium of 10 mm. In the left cornu of the uterus a gestational sac distinct from the endometrial cavity and surrounded by the myometrium was identified. The right ovary was of normal shape and size. Because of the patient's prior operative history the decision was made to proceed with an operative intervention and a diagnostic laparoscopy was performed under general endotrachela anesthesia. This revealed absence of the left adnexa and the otherwise normal right fallopian tube and the right ovary. At the left cornu of the uterus a 40 mm bulging mass was visualized, that appeared to be

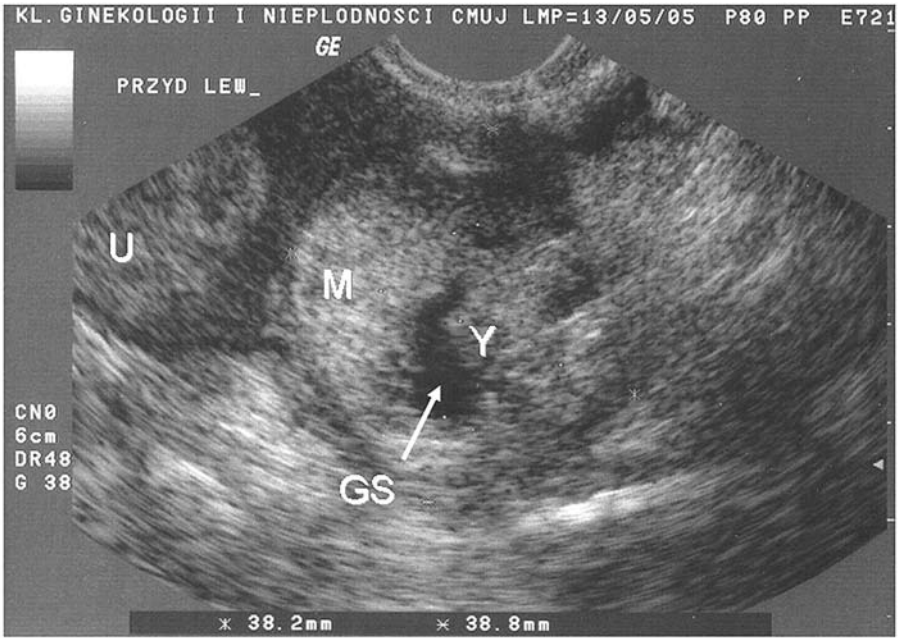

Figure 1. Transvaginal ultrasound scan: M-myometrium, U- body of the uterus, Y-yolk sac, GS-gestational sac.

surrounded by the myometrium. Left cornual resection was performed via a laparoscopic approach. Control laboratory tests showed a continuous decrease in the serum human chorionic gonadotropin level (3024,2U/l; 864U/l). The patient had an uneventful postoperative course and was discharged home after 4 days. The histopathological examination of excised tissues revealed a degenerated decidua and a necrotic placental tissue with the oedematosus stroma.

Discussion

Interstitial pregnancy usually reflects prior uterine trauma including cesarean section, dilatation and curettage, myomectomy, hysteroscopy, manual removal of placenta and adenomiosis. The possibility of interstitial gestation after homolateral adnexectomy, although very rare, should not be excluded from routine differential diagnosis.

Diagnosis of intramural pregnancy by ultrasound is very difficult and usually unreliable. Final judgment and treatment used to be made intraoperatively but recently the role of magnetic resonance imaging (MRI) and hysteroscopy have been discussed. [2]. Several types of interstitial pregnancy treatment have been presented in literature including metotrexat therapy, both local and systemic, injection of potassium chloride into the gestation or uterine artery embolisation [4] and even a combined hysteroscopic and laparoscopic approach [3]. In this case, because of the patient's prior surgical history, a laparoscopic procedure was chosen.

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