Ovarian ectopic: A diagnostic dilemma

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ABSTRACT
Introduction: Ovarian ectopic pregnancy is one of the most uncommon types of ectopic pregnancy. Primary ovarian pregnancy occurs between 1/7,000 and 1/40,000 times in live births and accounts for between 0.5 and 3% of all ectopic pregnancies. The main risk factors include the intrauterine contraceptive device (IUCD), salpingitis, infertility, and assisted reproductive methods.

Case Description: A 31-year-old, Para 0+2 (with a past history of right salpingectomy for tubal ectopic in 2011) presented with worsening acute lower abdominal pain of 3 days duration. Her last menstrual period was 6 weeks ago and was regular. Initial diagnosis of ectopic was made as tenderness was elicited on abdomen examination with scan showing an empty uterus with free fluids. Emergency diagnostic laparoscopy showed negative findings. Serial B-HCG showed a persistent rise after surgery, from 28,836.6 to 38,633.8 U/L. The transvaginal scan showed an echogenic sac with fetal cardiac activity in the right ovary. The patient underwent a second diagnostic laparoscopy. Intraoperative findings were an enlarged right ovary with a product of conception, which was expelled upon manipulation. Right oophorectomy was subsequently performed. Histopathology report confirmed fragments of ovarian tissue with deciduoid stroma and attached chorionic villi which is consistent with ectopic (ovarian) pregnancy.

Discussion: The incidence of ovarian pregnancy is on the rise. While ultrasonography can identify ovarian ectopic in unruptured cases, it is not easy to differentiate ovarian from tubal ectopic in a ruptured state. Most patients present in a ruptured state, making medical management options largely impossible. Surgical management remains the main treatment option.