Introduction
Spontaneous bilateral ectopic pregnancy is rare, therefore preoperative diagnosis is uncommon. The incidence of simultaneous bilateral tubal pregnancies has been reported to range from 1 per 725 to 1 per 1580 ectopic pregnancies. It is usually diagnosed at the time of surgery.

Case: We hereby present a nulliparous lady with history of lower abdominal pain and bleeding per vaginum following a period of amenorrhea of two months. She underwent exploratory laparotomy. Intraoperatively left ruptured ectopic was present, salpingectomy was performed. Right sided tube was unruptured therefore linear salpingostomy was carried out conserving the tube in order to allow chance of natural conception in future cycles.

Conclusion: The diagnosis of bilateral ectopic pregnancy is generally made intraoperatively. This emphasizes on examining bilateral tubes at the time of surgery.

Keywords: Ectopic Pregnancy, Bilateral Salpingostomy, Salpingo-oophorectomy

Case History
A 25-year-old nulliparous female, housewife by occupation presented to the outpatient department of the Institute of Medical Sciences, Banaras Hindu University, Varanasi with complaints of amenorrhea of two months followed by continuous bleeding per vaginum for one and half months and pain lower abdomen for two months. Her per vaginal bleeding was mild (used 1 pad per day), continuous in nature.

Pain abdomen was a mild, continuous, dull ache confined to the lower abdomen. Urine Pregnancy Test (UPT) was negative. There was no history of vomiting or syncopal attack. There was no history of contraceptive use, treatment for infertility and tubercular contact.

On inquiring about her menstrual history she complained of continuous bleeding per vaginum since 8/6/12. She had a normal period on 17/4/12 and previous cycles were regular with average flow. There was no history of diabetes mellitus, hypertension, tubercular contact or any thyroid disorder.

On general examination the patient had moderate pallor. Other parameters were within normal limits. Systemic examination revealed a normal chest, cardiovascular and central nervous system.

On per abdominal examination there was no visible lump seen or felt and abdomen was soft and nontender. On per speculum examination there was slight bleeding through external os. Per vaginal examination showed that uterus was deviated to right side, fullness was present in right fornix and pouch of Douglas. Both lateral fornices were tender.

Her haematological parameters were hemoglobin 7.8mg/dl., TLC 16,000 cells/cu mm. Other blood indices Mean Corpuscular Hemoglobin (MCH) -25.5; Mean Corpuscular Volume (MCV) -69.9, Mean Corpuscular Hemoglobin Concentration (MCHC) -31.5. Renal function was within normal limits.

Ultrasound examination of pelvis revealed a normal size uterus. There was right adnexal mass of 10.5×7.6×7.3 cm and left adnexal mass of 5.9×5×3.5 cm. There was also minimal collection of fluid in pouch of Douglas.

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BILATERAL ECTOPIC PREGNANCY - A CASE REPORT
Dr. Nisha Rani Agrawal

Abstract
Background: Bilateral ectopic pregnancy in the absence of preceding induction of ovulation is rare. The incidence of simultaneous bilateral tubal pregnancies has been reported to range from 1 per 725 to 1 per 1580 ectopic pregnancies. This is thought to correspond to an occurrence of one per every 120,000 live births. In the past 20 years a three-fold increase in the incidence has been observed. Heterotopic as well as bilateral tubal ectopic pregnancies are more often described following assisted reproductive treatment.

The diagnosis of bilateral tubal pregnancy is usually made intraoperatively. This underscores the importance of identifying and closely examining both tubes at the time of surgery, even in the presence of significant adhesive disease. Various treatments have been employed with bilateral tubal pregnancies. These range from the extreme of a total abdominal hysterectomy with bilateral salpingo-oophorectomy to the conservative approach, with laparoscopic techniques involving salpingectomy or salpingostomy. Bilateral ectopic pregnancy in the absence of preceding induction of ovulation is and external unusual occurrence.

Keywords: Ectopic Pregnancy, Bilateral Salpingostomy, Salpingo-oophorectomy

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Patient was hospitalized. Hemoglobin was built up by blood transfusion. Exploratory laparatomy was performed. Multiple adhesions were present. Omentum was adhered to the uterus and both the adnexal masses were buried inside the adhesions. Sharp dissection was done to release the masses. Around 500 cc of blood clot was present. On the left side there was a ruptured ectopic. Left salpingectomy was done. On the right side an unruptured tubal ectopic pregnancy was present measuring 5×4 cm. Right sided salpingostomy was done and right tube was preserved (Figure 1). Patient received blood transfusion. Left side tube was sent for histopathology.

**Figure 1. Showing ruptured ectopic pregnancy**

**Discussion**

There are three possible explanations for a bilateral ectopic pregnancy:-

1) Simultaneous multiple ovulation  
2) Sequential impregnation  
3) Transperitoneal migration of trophoblastic cells from one extrauterine pregnancy to the other tube with implantation.

The incidence of ectopic pregnancy has been reported to be increasing in many countries in recent years as a result of a number of factors: increase in rates of sexually transmitted infections that damage the fallopian tubes, the use of antibiotic treatments for pelvic inflammatory disease rather than surgical removal of the tubes, more accurate methods for early detection of ectopic pregnancy, increased use of assisted reproductive technologies, and increased rates of tubal sterilization. Clinical features can vary widely, from an asymptomatic patient to abdominal pain and hypovolemic shock when ectopic pregnancy is diagnosed on ultrasound. There may be a lack of correlation between the ultrasound findings and β-hCG levels.\(^{8,9}\)

Ultrasoundography may fail to diagnose an extrauterine pregnancy. The serum β-hCG level has not been proven to be diagnostic. On occasion the tilters are comparable to those of a normal intrauterine pregnancy. In most cases, laparoscopy is diagnostic and therapeutic. It is important to inspect both adnexae for the presence of two simultaneous ectopic pregnancies. There are several case reports of failure if missed out. The histopathological examination is essential to confirm the diagnosis with the identification, at least, of chorionic villi in both tubes.

There are no specific guidelines for treatment, but those for unilateral ectopic pregnancy could be applied. The possibilities include observation, ultrasound-guided methotrexate injection, intramuscular methotrexate injection, laparoscopy (generally with salpingostomy or salpingectomy) and laparotomy. To rule out a persistent trophoblast, it is necessary to follow the β-hCG serum concentrations until its complete disappearance.

**Conclusion**

Bilateral ectopic pregnancy in the absence of preceding induction of ovulation is the rarest form of ectopic pregnancy. This is thought to correspond to an occurrence of one per every 200,000 live births. This demonstrates the importance of identifying and closely examining both the tubes at the time of surgery.

**Editor’s comment**

The diagnosis of bilateral tubal pregnancy is generally made intra-operatively, therefore identifying and examining both tubes at the time of surgery is critical. In the presented case, left salpingectomy due to ruptured ectopic was performed. Since, the right tube was intact, right salpingostomy was done to preserve fertility.

**References**


