A Ruptured Cornual Ectopic Pregnancy at 17 Weeks Gestation: A Case Report

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Abstract
Cornual pregnancy is a specific variety of ectopic gestation which occurs in the rudimentary horn of the uterus. It often rupture later than other tubal pregnancies because the myometrium is more distensible than the fallopian tube. Traditionally, the treatment is cornual resection (removal of rudimentary horn) or hysterectomy where the pedicle is short and the attachment is wide. Here, we report a case where cornual pregnancy was diagnosed at 17 weeks of gestation after uterine rupture and profound haemorrhage. The patient underwent laparotomy followed by cornual resection with salpingectomy.

Introduction:
Cornual pregnancy is a rare form of ectopic pregnancy. Interstitial pregnancies account for 2-4% of ectopic pregnancies and 20% of cases that advances beyond 12 wks of gestation ends in rupture1. As pregnancy location is within the myometrium there is greater room for expansion and rupture occurs characteristically during the fourth or fifth gestation2. It is very difficult to make a diagnosis of cornual pregnancy before rupture. We report a case where cornual pregnancy was diagnosed at 17 weeks of gestation after uterus rupture and profuse intra-abdominal haemorrhage.

Case Report:
A 22 yrs old lady admitted in our hospital with history of severe abdominal pain and sweating for 5 hours at 17 weeks of gestation. Her temperature recorded 96°F, pulse rate was 115 beats/min and blood pressure was 80/50 mm Hg. The lower abdomen was slightly distented and tender. She was severely anaemic and dehydrated. She had gestational diabetes mellitus at 11 weeks of pregnancy. She gave a history of spontaneous abortion at 10 weeks of pregnancy 2 years ago. Initial laboratory tests included Haemoglobin was 7 gm%; haematocrit was 22.6 % and platelet count was within normal limit. On abdominal ultrasonography, uterus found normal in size, endometrial cavity was empty and a 17 weeks old dead fetus was in the abdominal cavity with massive free fluid. An emergency laparotomy was performed under general anaesthesia with transfusion of 3 bags of fresh blood. There was approximately 3000 ml of blood in the abdominal cavity with a 16 cm male fetus protruded from ruptured right cornual region of the uterus. Placenta adherent to right horn of uterus which was ruptured. Left fallopian tube and both ovaries were normal. Right horn of the uterus with right tube was dissected and bleeding was secured. Perioperatively she received in total 4 units of blood. A drain tube was kept in peritoneal cavity which was removed on 3rd postoperative day. The postoperative period was uneventful and she was discharged on 6th postoperative day.

Discussion
Cornual pregnancy is the least frequent variety of ectopic pregnancy and its occurrence is rare. The etiologic factors for cornual pregnancy are pelvic inflammatory disease, tumour, a high number of transferred embryos, a transfer near the uterine horn, excessive pressure on the syringe during the transfer, or difficulties during the ET procedure3. Bilateral
pregnancy. These criteria are: no gestation sac in the presence of a positive hCG level indicating pregnancy is diagnosed with ultrasonographical criteria before rupture or hemorrhage takes place. Cornual In general, ectopic gestation is rarely diagnosed at the moment of transfer as possible causes. The quality of the embryos and the hormonal milieu related or not related to endometriosis, are an important risk factor. Some authors also consider the presence of a positive hCG level indicating pregnancy in reducing the morbidity and mortality from ectopic pregnancy.

References


