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Ovarian Ectopic Pregnancy (About A Case)

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ABSTRACT

Ovarian pregnancy is a rare entity among ectopic pregnancies where the ovary is the seat of implantation. The risk factors are different from those for tubal pregnancy. Its diagnosis is difficult to establish with certainty. Treatment is usually surgical. We report the case of an ovarian pregnancy diagnose in Our department. The aim is to support the clinical and therapeutic features of ovarian pregnancy.

Keywords

Ovarian pregnancy, Risk factors, Diagnosis, Histology.

Introduction

Ectopic pregnancy (GEU) is a medico-surgical emergency on the one hand because of the hemorrhagic risk which can be life-threatening, and on the other hand because of its frequent association with infertility. The tube is the usual site of ectopic pregnancy (93% of cases) followed by the ovary which occupies second place [1]. In fact, ovarian pregnancy accounts for 3% of all ectopic pregnancies [2]. The exact mechanism leading to GO is still unclear [3].

By comparing with other locations, cases of ovarian pregnancy have progressed until the 2nd trimester, or even to term [4]. It occurs in 1/2100 to 1/7000 pregnancies [5].

The preoperative diagnosis of this type of pregnancy is difficult, often certainty is obtained during the operation, although the surgical criteria remain difficult to prove [6]. The presence of the ovarian implantation zone on histopathological examination is optimal to confirm the diagnosis [3].

The objective of this work is to study, through a case of ovarian pregnancy and a review of the literature, the semiological features, diagnostic and therapeutic criteria of this particular pathology.

Observation

We report the case of a 26-year-old woman with primigravidae primiparae, with no particular pathological history, having a regular menstrual cycle without particular risk factors, in particular no toxic habits, no taking microprogestogens, no establishment of a intrauterine device. Symptoms began four days before her admission with the installation of pelvic pain in a context of general condition conservation without any other associated sign. On clinical examination at admission, the patient had tachycardia at 110 beats per minute, polypneic at 20 cycles per minute, with discolored conjunctivae, the abdomen was tender on palpation with a Douglas cry or digital rectal examination. After conditioning, pelvic ultrasound revealed a latero-uterine mass of 3.78 x 3. 66cm with an effusion of medium abundance in favor of a ruptured left ectopic pregnancy without being able to specify with certainty the tubal or ovarian location of the mass. The BHCG level was positive at 5300IU/ml.

The surgical exploration objectified the presence of a large effusion aspirated 1000ml, the right appendix was without abnormality, and on the left the ovary was the site of a ruptured ectopic pregnancy. A directed abortion was performed with preservation of the appendix. The BHCG rate achieved 48 hours after the procedure rose to 1091 and then went negative after 15 days.

Discussion

Ovarian pregnancy (GO) accounts for 3% of ectopic pregnancies [2]. First suspected by Mercureus in 1614 and proven from other works cited by Grall [7].

Its pathophysiology is not well known, it seems to be secondary to a reflux of the fertilized oocyte towards the ovary [8]. Cases of GO after in vitro fertilization reported in the literature support the theory of reflux [6]. The population at risk is most often fertile, multiparous and wearing an IUD [9].

Clinically, the painful abdominopelvic symptomatology precedes the scene. These pains correspond to the rupture of the ovarian capsule during pregnancy and the constitution of the hemoperitoneum [6-10]. Patients are most often seen in an emergency setting, in a state of shock [11].

The diagnosis of ovarian pregnancy can be evoked on ultrasound by an efficient operator. We can demonstrate a gestational sac adjoining the ovary or as some have described, a hyperechoic double ring within a hypoechoic latero-uterine mass with or without an embryo [6]. Indeed, depending on the age of pregnancy, several ultrasound images have been described in the literature [12].

The anatomo-pathological examination is of capital importance because it is this which makes it possible to confirm the diagnosis of GO. It aims to eliminate primary abdominal pregnancies, those grafted on the ovary but resulting from a tubo-abdominal abortion, and those where the ovary is not the exclusive site of implantation, according to the criteria anatomical studies of Spielberg in 1878 [7].

The standard treatment for GO is surgical. Laparoscopy with conservative treatment is increasingly indicated [6-13]. Laparotomy keeps its indication for a major hemoperitoneum with an unstable hemodynamic state [14].

The medical treatment of GO is little described in the literature [15]. In fact, OG is often diagnosed at the stage of complications preventing recourse to first-line medical treatment [16].

Regarding its prognosis, GO, due to the absence of tubal involvement, does not constitute a risk factor for a new GEU [1]. A single case of GO recurrence has been described in the literature and involved the contralateral ovary [17].

Conclusion

Ectopic pregnancy is a gyneco-obstetric emergency, which remains a major diagnostic trap, it is serious because it presents a functional and sometimes vital emergency. Both its screening and its post-treatment monitoring require attendance and codified management in order to preserve the fertility of patients and avoid the risk of recurrence. Faced with clinical polymorphism. Laparoscopic treatment is an elegant, economical method that brings benefits to patients. This reliable technique contributes to the management of the pathology and its etiology, to treat GEU, to estimate the fertility prognosis and to specify the subsequent strategy in the event of infertility. However, the medical treatment of GEU has become a therapeutic reality.

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