

LAPAROSCOPIC TREATMENT OF INTRALIGAMENTOUS PREGNANCY

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The safety of laparoscopic treatment for tubal extrauterine pregnancies has been well described.¹ A search of the literature in MEDLINE revealed no previous reports concerning laparoscopic management of intraligamentous extrauterine gestations. Intraligamentous pregnancies are rare but can progress to a large size; fetal viability has been reported.²

Most extrauterine pregnancies treated laparoscopically have been tubal ectopic gestations, although ovarian pregnancies have been treated laparoscopically as well.³ A MEDLINE search showed no reports of laparoscopic treatment of other types of nontubal extrauterine pregnancies.

Case

A 26-year-old white woman, gravida 3, para 1-0-1-1, at 7 weeks from her last menstrual period, reported recent vaginal spotting. Neither tenderness nor adnexal mass was noted on examination. There was no evidence of intrauterine or extrauterine gestation on vaginal ultrasound. Quantitative β -hCG was found subsequently to be 22,140 mIU/mL. Because of communication difficulty, the patient was not seen until 4 days later, but at that time she was asymptomatic. She remained pain-free on bimanual examination. Repeat ultrasound revealed an adnexal mass consistent with a right tubal ectopic pregnancy.

The patient preferred to consider her options before deciding on the type of therapy. The next day, she complained of pelvic pain. Tenderness was localized to the right on bimanual examination. She declined methotrexate therapy, and plans were made for a surgical approach.

Laparoscopy was performed that evening, revealing a small right intraligamentous ectopic pregnancy. A less than 1-cm area of peritoneal separation was noted at the area of greatest bulge, well away from the ureter and major vessels. Bipolar scissors were used to incise the broad ligament at this location. Probes were used to exert pressure on the ectopic gestation. The trophoblastic tissue extruded through the opening was removed using a laparoscopic suction device. Hemostasis was maintained easily with electrocautery.

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The patient did well and was discharged home on the first postoperative day. Quantitative hCG values were followed serially. She was seen 10 months later for another pregnancy, which ended in miscarriage. Hysterosalpingogram performed after that miscarriage demonstrated bilateral tubal patency.

Comment

The patient described in this report had a small intraligamentous gestation which was treated successfully with laparoscopy. A larger intraligamentous pregnancy might not be suitable for a conservative surgical approach.

Expectant management has been described for tubal ectopic pregnancies, but would not be appropriate for intraligamentous pregnancies given their potential for progression to a large size. Methotrexate therapy might have been a good option for this patient, but she refused this form of therapy. Although methotrexate therapy has been described in the treatment of cervical ectopic gestations,⁴ a review of the literature in MEDLINE revealed no reports regarding intraligamentous gestations.

Laparoscopic surgery is a safe and effective approach for the treatment of tubal extrauterine gestations. This case shows that laparoscopy has the potential to be safe and effective in selected patients with nontubal extrauterine gestations.

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