

6-1984

Tubal Lavage in the Management of Ectopic Pregnancy

Samuel A. Motanya

William H. Pfeffer

Emile Sandelin

C. James Chuong

Follow this and additional works at: <https://scholarlycommons.henryford.com/hfhmedjournal>



Part of the [Life Sciences Commons](#), [Medical Specialties Commons](#), and the [Public Health Commons](#)

Recommended Citation

Motanya, Samuel A.; Pfeffer, William H.; Sandelin, Emile; and Chuong, C. James (1984) "Tubal Lavage in the Management of Ectopic Pregnancy," *Henry Ford Hospital Medical Journal* : Vol. 32 : No. 2 , 146. Available at: <https://scholarlycommons.henryford.com/hfhmedjournal/vol32/iss2/12>

This Article is brought to you for free and open access by Henry Ford Health System Scholarly Commons. It has been accepted for inclusion in Henry Ford Hospital Medical Journal by an authorized editor of Henry Ford Health System Scholarly Commons.

Clinical Note

Tubal Lavage in the Management of Ectopic Pregnancy

Samuel A. Motanya, MD,* William H. Pfeffer, MD,*
Emile Sandelin, MD,* and C. James Chuong, MD*

With venereal salpingitis at epidemic proportions, the incidence of tubal pregnancy continues to increase (1). Sensitive blood pregnancy tests and ultrasound have allowed us to diagnose more of these pregnancies in their early, unruptured state. Recently, physicians have developed an interest in resecting early tubal gestations through the laparoscope (2).

We report the case of unruptured tubal pregnancy which provided an opportunity to use a novel laparoscopic technique for extracting the pregnancy from the tube.

Case Report

A 17-year-old black girl, gravida 1 para 1, was admitted from the emergency room with a history of amenorrhea for two months, nausea, and lower abdominal pains for a week. Her temperature on admission was 38.0°C. Blood pressure and pulse were stable. Abdominal and pelvic exams revealed pelvic peritonitis, a normal sized uterus, cervical motion tenderness, bilateral adnexa tenderness, and no palpable adnexa mass. A urine pregnancy test was negative; hematocrit was 33%; and white blood count was 10,500 mm² with normal differential count. Culdocentesis yielded about 10 ml of turbid fluid.

Gonorrhea culture and blood radioimmunoassay-human chorionic gonadotropin (RIA-HCG) tests were ordered. After 24 hours of intravenous antibiotics, the patient's fever subsided, and her pain lessened. The gonorrhea culture proved positive. However, the quantitative assay of HCG in serum from admission was reported to be 85.7 mIU/ml. Serial hematocrits were stable at 32%. Pelvic ultrasound showed neither intrauterine gestation nor adnexa mass. In light of the positive pregnancy test, it was considered necessary to differentiate ectopic pregnancy from early intrauterine pregnancy by laparoscopy.

Laparoscopy was performed 36 hours after admission. The uterus and left fallopian tube appeared normal. A tubal pregnancy was noted on the right at the junction of the ampulla and the fimbria. The pregnancy could not be dislodged by milking the tube with laparoscopic forceps. After gently obstructing the left tube at the isthmus by an atraumatic forceps, we infused normal saline through a transcervical cannula. The trophoblastic tissue extruded from the tube and was re-

moved via the laparoscope. The abdomen was lavaged with Ringer's lactate. No bleeding was observed.

The postoperative course was uneventful. Serial hematocrits remained stable. The intravenous antibiotics were discontinued after 48 hours. Pathological study of the removed tissue confirmed tubal pregnancy. The patient was discharged on the third postoperative day. Quantitative RIA beta HCG was negative by the second week. Three months later, hysterosalpingography showed patent fallopian tubes bilaterally.

Discussion

The sensitive RIA beta HCG and ultrasound facilitated an early diagnosis of unruptured pregnancy and allowed the use of laparoscopic surgery. Laparoscopic surgery offers advantages over traditional resection by laparotomy. These include 1) shorter hospital stay, 2) shortened operating time, and 3) minimal raw peritoneal surfaces that may cause adhesion. However, a disadvantage of our technique of flushing out a tubal pregnancy is the risk of dissemination of endometriosis or infection.

Close follow-up of patients after laparoscopic surgery for tubal pregnancies is critical. Serial quantitative HCG serum will confirm that no viable trophoblastic tissue remains (3). Postoperative hysterosalpingography is recommended after three to four months to assess tubal patency. Transcervical tubal lavage is a simple technique that can be used when the pregnancy is located at the junction of the ampulla and fimbria. It does not require extensive laparoscopic experience and is less traumatic to tissues than extensive manipulations of the fimbria.

References

1. Strathy JH, Coulam CV, Marchbanks T, Annegers JF. Incidence of ectopic pregnancy in Rochester, Minnesota, 1950-1981. *Obstet Gynecol* 1984;64:37.
2. DeCherney AA, Romero R, Naftolin F. Surgical management of unruptured ectopic pregnancy. *Fertil Steril* 1981;35:21.
3. Maschiach S, Carp HJA, Serr DM. Nonoperative management of ectopic pregnancy: A preliminary report. *J Reprod Med* 1982; 27:127.

Submitted for publication: January 23, 1984

Accepted for publication: April 5, 1984

*Department of Obstetrics and Gynecology, Henry Ford Hospital

Address reprint requests to Dr. Pfeffer, 140 Lankelnow Medical Building, Philadelphia, PA 19151.