

## The Eye Does Not See What the Mind Does Not Know

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### Day 1 at 07:45 Ain Shams University-Maternity Hospital (ASUMH)-Reception Room (RR).

A 30 years old, para 1 patient is admitted with a progressively increasing colicky lower abdominal pain of 4 days duration. The pain is in her left loin, referred to the left iliac fossa and suprapubic regions and is not associated with fever, gastrointestinal or urinary symptoms. The patient has regular periods, the last one being 3 weeks ago and has been using an IUCD for 2 years now. Upon medical consultation, the latter was removed and medical treatment was prescribed one day before admission. On examination, the patient's general condition is fair, her blood pressure is 110/70 mmHg, pulse 88 bpm and temperature 37°C. Her abdomen is lax with mild tenderness in the left loin, iliac fossa and suprapubic regions, mostly in the left loin. Vaginal examination reveals tenderness in the anterior fornix with no cervical motion tenderness.

Initial investigations reveal a positive pregnancy test, a normal complete blood count and urine analysis. An abdominopelvic ultrasound scan shows an anteverted, normal sized, empty uterus and no adnexal mass nor abnormalities in the pouch of Douglas.

*How would you proceed in your initial management of a similar case?*

### Day 2 at 10:00 ASUMH- The In-patients Ward.

The patient is admitted for observation and further investigation to exclude ectopic pregnancy. Her  $\beta$ -hCG titre is 7554 mIU/ml. She is still vitally stable. Her abdomen is lax with mild tenderness mainly in suprapubic region. A transvaginal ultrasound scan reveals a single intrauterine gestational sac containing a 10 mm embryonic pole, corresponding to 7 weeks gestation. A fetal heart beat can not be detected. A right unilocular ovarian cyst is found (5x5.5 cm in size, with clear fluid content) cm in continuity with a hyperechoic mass (4x4.5 cm) and a rim of fluid in the pouch of Douglas.

*What is your differential diagnosis and plan of management for this patient?*

### Day 3 at 09:30 ASUMH- The In-patients Ward.

The patient is vitally stable. Her  $\beta$ -hCG titre is 11808 mIU/ml. A decision is taken for laparoscopy on the next morning. At 21:00, the patient develops increased abdominal pain together with rigidity and rebound tenderness. She becomes tachycardic (106 bpm). Her hemoglobin level drops from 10.6 g/dl on admission to 8.8 g/dl. The decision is changed to immediate laparotomy.

*What is your comment on the management done so far?*

### Day 3 at 22:00 ASUMH- Operation Rooms.

On laparotomy, a midline subumbilical incision is done. Hemoperitoneum of one liter of altered blood is found. A ruptured left tubal pregnancy is detected and treated by salpingectomy. Then, a D & C is done. Two units of packed red blood cells are transfused.

*How would you counsel the patient postoperatively?*

**Day 6 at 12:00 ASUMH- The In-patients Ward.**

The patient is recovering normally. The pathology report reveals a ruptured tubal pregnancy and remnants of conception in the uterine curettage sample. The diagnosis of heterotopic pregnancy is confirmed. Prior to discharge, the patient is counseled regarding the need for contraception, the risk of recurrence of ectopic pregnancy and the need for antibiotics covering possible chlamydial infection.

**Comment by the Editorial Board**

Every female presenting with abdominal pain or unexplained abdominal or pelvic symptoms should have a pregnancy test to exclude ectopic pregnancy. We would like to attract the reader attention that this case was missed from the medical consultation which preceded the patient's presentation to our hospital. *The eye does not see what the mind does not know!* This case shows how much transvaginal ultrasound is superior to the transabdominal route in diagnosing such cases. Although the diagnosis of a heterotopic pregnancy is very rarely seen in absence of a history of IVF/ICSI, yet it should still be considered in cases similar to this one. The most common differential diagnosis is an intrauterine pregnancy with a complicated ovarian cyst. This case might have benefited more if she had an urgent laparoscopy on the same day of the transvaginal scan or at least on the day of the second hCG titre. This might have avoided the midline laparotomy and the blood transfusion that she underwent. Nevertheless, the managing team may be excused because of the confusing nature of such a case. The postoperative counseling of such cases must include discussing contraception, the risk of recurrence of ectopic pregnancy and the need for antibiotics covering possible chlamydial infection.

**A simple pregnancy test and a transvaginal ultrasound are available almost everywhere. A cautious and attentive mind is what it really takes to make all the difference.**