Case Study

CASE REPORTPOSTOPERATIVE CASE OF EXPLORE LAPAROTOMYFOR RUPTURED ECTOPIC PREGNANCY WITH SEPTICEMIA

Abstract:

Introduction:

Ectopic pregnancy is a pregnancy problem when the embryo attaches itself outside the uterus. Signs and symptoms include abdominal pain and vaginal bleeding, but less than 50 percent of affected women have both. it happened. Excessive bleeding may lead to a rapid heartbeat, fainting, or panic attack. Without abnormalities, the fetus can no longer survive. Obstetricians and gynaecologists face various obstacles in dealing with Jehovah's Witnesses.

Main symptoms and/or important clinical findings:

A 20-year-old man with a post-operative case of Explore Laparotomy For Ruptured Ectopic Pregnancy with pyosalpinx with septicemia underwent surgery on 14/02/2021 investigating Laparotomy under GA. His diagnostic ultrasonography was performed. Complete the blood test. She had not dropped down before 8 days she was a primigravida at 2 months of pregnancy and then had abdominal pain as she grew stronger over time.

The main diagnoses, therapeutic interventions, and outcomes:

A 20-year-old man with a post-operative case of Explore Laparotomy for Ruptured Ectopic Pregnancy with pyosalpinx withsepticemia, with a complaint of abdominal pain, Treatment began on the day he received V fluids, Antibiotics Injectable. Initiated, Zonac suppository PR consulted. TPR Charting treatment interventions, I / O Charting, abortion chart,

Nursing Perspectives: laboratory techniques are urgently required. To limit the development of treatments to enhance the outcome.

Conclusion: Although it is not uncommon for an ectopic pregnancy to exceed the first trimester, it does occur occasionally. As a result, in any emergency, abdominal surgery during pregnancy, Today, early intervention saves lives and reduces morbidity, but ectopic

pregnancy still kills 4 to 10% of pregnant women and results in a higher ectopic pregnancy rate following pregnancy.

Keywords: Ectopic pregnancy,Ruptured ectopic pregnancy, Hemoperitoneum,

Introduction

Ectopic pregnancy is a pregnancy in which a blastocyst is inserted outside the endometrium canal [1]. External pregnancy is estimated at 1.3% to 2.4% of all pregnancies [2]. 90% of ectopic pregnancies originate in the tublopian tubes, and implants remain in the uterine cavity, uterus, myometrium, and other sites [3]. Ectopic pregnancy can present as abdominal or pelvic pain, amenorrhea, or bleeding in the vagina of the first trimester. Transvaginal ultrasound and serological confirmation of pregnancy are low requirements for the diagnosis of ectopic pregnancy. [4]. Only a few pregnancy events are implanted in the uterosacral ligament recorded in the literature. These pregnancies occur at a rate of 1 in 10,000 to 1 in 30,000 pregnancies, with an ectopic pregnancy around 1. [5, 6]. This pregnancy has symptoms similar to those of ectopic tubal pregnancy and is difficult to diagnose with ultrasonography; We may endanger our health if not treated immediately. To understand the biology of this disease and the best control strategies, explanations for such cases are needed. In addition, we look at other cases of ectopic pregnancy within the uterosacral ligament to learn more about the risk factors and treatment options for these drugs.

Patience Details:

A 20-year-old woman guilty of operating a laparotomy for a broken ectopic pregnancy was admitted on 16/02/2020 for further treatment.

Primary anxiety and patient symptoms

A 20-year-old woman with a functional laparotomy post for ectopic pregnancy was diagnosed with I / V / O hypotension to continue to treat a patient's complaint of severe abdominal pain, pyosalpinx with septicemia variable BP.TPR / BP/charting, I / O charting, AG charting, advice O2 4 lit I / V Fluids & antibiotic treatment has started, charting drain charting

Medical, Family, and Social History:

Patients were not severe before 8 days. Primigravida with two months of pregnancy. She later developed abdominal pain and later visited a few doctors, but no direct diagnosis was made in Kinwat on February 14 a diagnosis of ectopic pregnancy was sent to Adilabad.

When an emergency laparotomy was performed on a diagnosis of ruptured ectopic pregnancy with septicemia, a blood transfusion indicating two points of insertion after surgery and then altering her BP was directed to a higher center at AVBRH in a standardized setting. There was no history of bladder and intestinal symptoms. No significant family history, she is a stay-at-home mom.

Past active interventions and outcomes:

Not reported

DISCOVERY

Significant physical examination (PE) and important clinical findings.

In a typical diagnostic patient, we were informed, focused and there were significant risk factors associated with it. All blood tests performed in that WBC Count are 19400 Total Platelet Count -3.23 KFT- Sodium- 137, Potassium -5.2., LFT- Globulin calculated Parameter- 3.1., Injectable treatment was started.

Timeline:

The patient had asymptomatic for 8 days He is a primigravida with 2 months of pregnancy. she had severe abdominal pain but no clear diagnosis was made for ectopic pregnancy & emergency examination laparotomy was performed for a broken ectopic pregnancy with pyosalpinx with septicemia.

HISTORICAL AND MODERN DETAILS IN THIS CARE

SCHEDULED AS TIME

Treatment was started for pyosalpinx with septicemia on the day of admission 1- day V V fluids, injections, and closures monitored by the patient's general condition, 2-day B.P standard, the 3-day general condition is satisfactory.

Testing

Abdominal tests performed & All blood tests performed, CompleteHemogramandUrine tests performed Diagnostic challenges - No diagnostic challenges addressed.

Forecast: His prediction is good for balance.

MEDICAL INTERVIEWS:

In the present study, you found I V fluids, Injectable. -Meropenem-1 gm, Inj. Metro, Inj. Pan-40mg, Inj. Tramadol in IV Fluid, Inj. Pause - 500mg advice for Zonac suppository PR. Everything is necessary and thoroughly investigated by blood. TPR Charting treatment interventions, I / O Charting, abortion chart, allow toLiquid Diet.

Changes in therapeutic (sensible) interventions:

No challenges were reported in treatment interventions.

Follow-up and Results: In addition to all the care patients performing well, he was given discharge on the seventh day. A. He was advised to strictly avoid hard work. You are advised to take complete bed rest.

Important follow-up diagnoses and other test results:

Avoid lifting heavy weights, preventing constipation, and coughing controlled.

Adherence to intervention and tolerance (How is this tested?)

The intervention was well tolerated and well tolerated by the patient.

Adverse and Unexpected Events: No adverse events were noted.

DISCUSSION

A scientific discussion of the strengths AND limitations associated with this case report Ectopic pregnancy is a common problem in the first trimester of pregnancy. It is a life-threatening disease that continues to be considered the leading cause of maternal mortality, accounting for 9 to 13% of all pregnancy-related deaths. [7] Most ectopic pregnancies are implanted in various parts of the fallopian tube, of which the ampulla (70%) is the most common, followed by an isthmus (12%), fimbria (11.1%), and interstitium (11.1). %). (2.4 percent) [8]. Previous ectopic pregnancy, tuberculosis injury or pelvic infection or previous pelvic surgery, birth history, IVF treatment, maternal age, and smoking are all risk factors for pregnancy. ectopic. in women with ectopic pregnancy, they do not have the risk factors [9]. Such conditions are rare because the fallopian tube is seldom enlarged to the point of conception in the second or third trimester. [10]. Ectopic pregnancy is still a difficult problem to find in the emergency room. In a patient with a suspected ectopic pregnancy, chemotherapy (BhCG) and competent pelvic examination play an important role in speeding

up the management of patients. In the emergency room, ectopic pregnancy remains a major problem. In a patient who is pregnant with an ectopic pregnancy, a chemical test (BhCG) and a competent skill test play a very important role in accelerating the management of patients. [11] The choice of the best treatment is determined by several parameters, including patient stability, BhCG level, pregnancy bag size, and future fertility goal. Formal methotrexate can be used to treat single ectopic pregnancies. [12]. Ectopic weight loss, hemodynamic instability of an unstable patient, and the accumulation of intracranial hemorrhage seen in ultrasound imaging require urgent laparotomy and salpingectomy appropriate for us. Primary peritoneal pregnancy is a very rare gynaecologic condition. Ectopic pregnancy is estimated to occur in 1 in 10,000 to 1 in 30,000 pregnancies, about 1 person in 100. [13, 14]. The risks in patients are similar to those of a broken tubal pregnancy, but early detection is difficult. [14]. Primary peritoneal pregnancy should meet the following criteria, according to Studdiford: both tubes and ovaries should appear normal without evidence of rupture or injury, there should be no utero peritoneal fistula, and pregnancy should be limited to the peritoneal surface as well. happened early enough to prevent a second installation. [15]. Ectopic pregnancy within the uterosacral ligament was described in a 28-year-old patient (G2P0010), who was medically removed following a laparotomy. In this patient's condition, there were no risk factors. [16]. The first example was G1P0 a 33-year-old woman with a history of pelvic endometriosis and an ectopic pregnancy that broke below the uterosacral ligament. Lo and Lau described two cases; The first case was G1P0 a 33-year-old woman with a history of endometriosis in the hip who had an ectopic pregnancy that broke down under the uterosacral canal [17]. Laparoscopy, later transformed into laparotomy, was used to treat her surgery. 17]. The second example was a 32-year-old G4P2 that presented the same symptom but had no side effects and was treated for laparoscopic cuts of disturbed tissue. [17]. In 30-year-old G3P1011 with no known risk factors, ruptured ectopic pregnancy within the uterosacral ligament was treated with laparoscopy and a single dose of parenteral methotrexate 50 mg / m2. One week later, her beta-hCG levels dropped dramatically (from 5699 mIU / mL to 81 mIU / mL). U / mL). [18]. Sperm accumulates behind the cul-de-sac and the egg collects in the same region due to the normal flow of peritoneal fluid into the uterus that extends into the uterosacral artery. [18]. Before her hysteroscopic surgery, a patient's beta-hCG urine test was negative, indicating that the pregnancy would not have occurred immediately. We also believe that our case met the Studdiford process and was a major pregnancy, as mentioned earlier. Treatment of pregnancy in the uterosacral ligament will vary depending on the patient's condition, age of the pregnancy, ectopic size, and the surgeon's experience. [17] The administration of methotrexate and/or intracardiac potassium chloride has also been

previously reported in the treatment of constipation. Not all previous models of pregnancy ligos ligament are associated with beta-hCG levels. [18].

Conclusion

Although it is not uncommon for an ectopic pregnancy to exceed the first trimester, it does occur occasionally. As a result, in any emergency, abdominal surgery during pregnancy, Today, early intervention saves lives and reduces morbidity, but ectopic pregnancy still kills 4 to 10% of pregnant women and results in a higher ectopic pregnancy rate following pregnancy.

Consent Disclaimer:

As per international standard or university standard, patient's consent has been collected and preserved by the authors.

References:

1. American College of Obstetricians and Gynecologists ACOG practice bulletin no. 191. Tubal ectopic pregnancy. *Obstet Gynecol.* 2018;131:0. [Google Scholar]

2. The diagnosis and treatment of ectopic pregnancy. Taran FA, Kagan KO, Hübner M, Hoopmann M, Wallwiener D, Brucker S. *DtschArztebl Int.* 2015;112:693–704. [PMC free article] [PubMed] [Google Scholar]

3. Incidence, diagnosis and management of tubal and nontubal ectopic pregnancies: a review. Panelli DM, Phillips CH, Brady PC. *Fertil Res Pract.* 2015;1:15. [PMC free article] [PubMed] [Google Scholar]

4. Early diagnosis of ectopic pregnancy. Belics Z, Gérecz B, Csákány MG. *OrvHetil.* 2014;155:1158–1166. [PubMed] [Google Scholar]

5.H. K. Atrash, A. Friede, and C. J. Hogue, "Abdominal pregnancy in the United States: frequency and maternal mortality," *Obstetrics and Gynecology*, vol. 69, 3, Part 1, pp. 333–337, 1987.View at: Google Scholar

6.F. G. Hailu, G. T. Yihunie, A. A. Essa, and W. . Tsega, "Advanced abdominal pregnancy, with live fetus and severe preeclampsia, case report," *BMC Pregnancy and Childbirth*, vol. 17, no. 1, p. 243, 2017.View at: Publisher Site | Google Scholar

7. The diagnosis and treatment of ectopic pregnancy. Taran FA, Kagan KO, Hübner M, Hoopmann M, Wallwiener D, Brucker S. *DtschArztebl Int.* 2015;112:693–704. [PMC free article] [PubMed] [Google Scholar.

8. An advanced second trimester tubal pregnancy: case report. Khalil MM, Shazly SM, Badran EY. *Middle East FertilSoc J.* 2012;17:136–138. [Google Scholar]

9. Unruptured tubal pregnancy in the second trimester. Diarra M, Guèye N, Guèye M, Thiam I, Mbaye M, Magib A. http://www.southsudanmedicaljournal.com/archive/november-2013/unruptured-tubal-pregnancy-in-the-second-trimester.html *South Sudan Med J.* 2013;6:95–96.

10.An advanced second trimester tubal pregnancy: case report. Khalil MM, Shazly SM, Badran EY. *Middle East FertilSoc J.* 2012;17:136–138. [Google Scholar

11. Interstitial pregnancy: case report of atypical ectopic pregnancy. Santos L, Oliveira S, Rocha L, et al. *Cureus.* 2020;12:0. [PMC free article] [PubMed] [Google Scholar]

12.The diagnosis and treatment of ectopic pregnancy. Taran FA, Kagan KO, Hübner M, Hoopmann M, Wallwiener D, Brucker S. *DtschArztebl Int.* 2015;112:693–704. [PMC free article] [PubMed] [Google Scholar]

13.W. E. Studdiford, “Primary peritoneal pregnancy,” *American Journal of Obstetrics and Gynecology*, vol. 44, no. 3, pp. 487–491, 1942.View at: Publisher Site | Google Scholar

14.J. S. Shin, Y. J. Moon, S. R. Kim, K. T. Kim, H. Moon, and Y. Y. Hwang, “Primary peritoneal pregnancy implanted on the uterosacral ligament: a case report,” *Journal of Korean Medical Science*, vol. 15, no. 3, pp. 359–362, 2000.View at: Publisher Site | Google Scholar

15.K. W.-K. Lo and T.-K. Lau, “Ectopic pregnancy in uterosacral ligament,” *The Journal of Obstetrics and Gynaecology Research*, vol. 23, no. 5, pp. 415–419, 1997.View at: Publisher Site | Google

16.World Health Organization. Gender and genetics: assisted reproductive technologies (ARTs). Geneva: World Health Organization; 2003. Available from: http://www.who.int/genomics/gender/en/index6.html.

17. Mallikarjuna M, Rajeshwari B. Selected risk factors of infertility in women: case control study. Int J ReprodContraceptObstet Gynecol. 2015;4(6):1714–9.

18. Ombelet W, Cooke I, Dyer S, Serour G, Devroey P. Infertility and the provision of infertility medical services in developing countries. Hum Reprod Update. 2008;14(6):605–62.