

Successful treatment of interstitial ectopic pregnancy using methotrexate

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INTRODUCTION

The oocyte fertilization occurs in the Fallopian tube (FT). The migration of fertilized oocytes into the uterus is facilitated by FT cilia and muscles. FT dysfunction and/or inflammation is implicated in oocytes retention and subsequent ectopic pregnancy (EP) [1]. The incidence of EP is 1.3–2.4%, and ruptured EP is a direct cause of maternal death in the first trimester of pregnancy [2].

The rising EP incidence can be explained by the increased, assisted reproduction techniques rate, tubal surgeries, and improved diagnostic techniques [2].

Prior tubal surgery, sterilization, prior EP, and intrauterine contraceptive device were considered high-risk factors for the EP. While infertility, prior pelvic inflammatory disease, smoking, and multiple partners were considered moderate risk factors for the EP [3].

This clinical vignette represents an interstitial ectopic pregnancy (IEP) successfully treated using methotrexate (MTX).

CLINICAL VIGNETTE

A 32-years-old woman, P3, previous 3 cesarean sections, presented to the emergency room, with vaginal spotting after positive pregnancy test at 6 weeks' gestation. She was diagnosed as IEP because the departmental ultrasound at initial β -human chorionic gonadotropin (β -hCG) 1540 mIU/mL, showed an empty uterus, with an eccentric gestational sac (GS) without fetal echo or fetal pulsation. The eccentric GS is more than 1 cm away from the lateral endometrial edge and surrounded by less than 5 mm myometrium, with positive interstitial line sign (ILS) (Fig. 1).

The studied woman counselled for medical treatment using MTX, because the IEP was intact, with no fetal echo or fetal pulsation, and desired future fertility. She was also counselled regarding the MTX-side effects, failure rate, serial β -hCG assay and follow up.

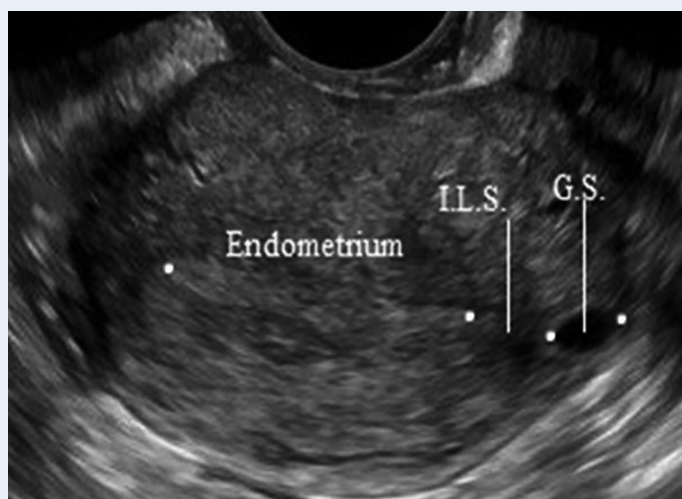


Figure 1. An ultrasound image shows an eccentric gestational sac (GS) > 1 cm away from the lateral endometrial edge and the interstitial line sign (ILS) as an echogenic line extending from the eccentric GS to the endometrial line

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After written consent, she received 50 mg MTX (50 mg/BSA) at initial β -hCG 1540 mIU/mL. The 4th day β -hCG after the MTX slightly increased to 1660 mIU/mL, while the 7th day β -hCG was 1230 mIU/mL (> 15% drop of β -hCG [25.9%]). The 2nd week β -hCG was 480 mIU/mL, while, the 3rd week β -hCG was 143 mIU/mL, and the 4th week β -hCG was 53 mIU/mL (the GS completely disappeared by the follow-up ultrasound scan). The β -hCG returned to normal non-pregnant level on the 5th week after the MTX [5.1 mIU/mL (normal β -hCG 0.0–10 mIU/mL)].

A departmental approval and written consent were obtained to publish the studied women data as a clinical vignette.

DISCUSSION

The IEP occurs following fertilized ovum implantation in the interstitial portion of the FT when it traverses the uterine muscles to enter the uterine cavity [2].

The ultrasound diagnostic criteria of the IEP include an empty uterus with an eccentric GS. The eccentric GS is more than 1 cm away from the lateral endometrial edge and surrounded by less than 5 mm myometrium. The ILS is an echogenic line extending from the eccentric GS to the endometrial line and represents the interstitial portion of the FT (ILS has 80% sensitivity in diagnosing IEP) [3–5].

The treatment options for IEP depends on the gestational age at diagnosis, desired future fertility, and whether the IEP is intact or ruptured [2].

The non-surgical (medical) treatment options can be used for intact IEP [2]. The success rate of systemic MTX in the treatment of IEPs was 80%, even with high β -hCG levels and presence of fetal cardiac activity [2].

Local MTX injection can be used for treatment of IEPs, while local potassium chloride (20%) injection is preferred in IEPs with concomitant viable intrauterine pregnancy. Follow-up using serial β -hCG assay and ultrasound is needed after the medical treatment for IEPs [2].

Decreased β -hCG by \geq 15% on day 7 indicates successful MTX treatment, and the β -hCG should be monitored weekly till it reaches the non-pregnant level [2]. Another MTX-dose or surgical options should be considered, if the β -hCG does not decrease adequately (< 15% on day 7) after MTX or increased [2].

The medical treatment using MTX for the studied IEP-case, was successful because the 4th day β -hCG decreased by > 15% (25.9%) on the 7th day after the MTX (from 1660 to 1230 mIU/mL; respectively) and returned to normal non-pregnant level (5.1 mIU/mL) on the 5th week after the MTX.

CONCLUSION

The MTX is an effective treatment option for selected cases of intact IEPs, with desired future fertility after proper counselling.

Article information and declarations

Declaration of consent

A departmental approval and written consent were obtained to publish the studied women data as a clinical vignette.

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Conflict of interest

Authors declare no conflict of interest.

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