LAPAROSCOPIC DIAGNOSIS OF TUBARIC PREGNANCY IN EVOLUTION AND RECONSTRUCTIVE SURGICAL TREATMENT

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SUMMARY

The Authors report the results obtained on 22 selected cases of tubaric pregnancy in evolution and treated by reconstructive plastic surgery.

They point out the necessity of a very precocious laparoscopic diagnosis in order to obtain a better functional recovery of the Falloppian tube.

On the basis of the results, the Authors suggest a more frequent reconstructive treatment of the tubaric pregnancy.

INTRODUCTION

Among the different types of ectopic pregnancy the tubaric is the most frequent one (95% of the cases).

Recent data from literature sustain a progressive increase in the number of ectopic pregnancies in the last decades.

The reasons of such a higher incidence are numerous: they are essentially due to improved methods of the tubaric pathology treatment and to the decreased incidence of bilateral occlusion, but in advantage for obstacles to the migrating ovum and its consequent uterine implantation.

The improved surgical techniques of salpingoplasty have contributed to resolve severe tubaric sterilities, but have also contributed to an increase in the number of tubaric pregnancies.

It is important to point out the frequent young age and nulliparity of the patients: some AA. report an incidence of 68% in the nulliparous and a medium age of 25-30 years (2).

All these factors induce the necessity of emphasizing for a revision of the diagnostic and therapeutic management of the cases of tubaric pregnancy. The diagnostic methods at our disposition, and particularly the endoscopic ones, make a precocious diagnosis possible at an oligosymptomatic stage (with few objective and subjective symptoms of the evoluting tubaric pregnancy), with the possibility of an immediate conservative surgical treatment (6).

The demolitive surgery (salpingectomy and emisalpingectomy), till few years ago an elective treatment of all the cases of tubaric pregnancy, is now under discussion and used only in case of conclamed tubaric rupture with frayed and oedematous tissues and with parietal hematomas, which makes extremely difficult a reconstruction of the oviduct.

In the last few years we have tried to diagnose a tubaric pregnancy in a very precocious phase, depistating outpatients presenting a symptomatology which could make supect a tubaric implant of the fertilized ovum.

The patient with a supected diagnosis, underwent a laparoscopy. If the laparoscopic report confirmed the diagnosis (figs. 1, 2) she underwent immediately a tubaric plastic surgery.

The surgical methods of tubaric plastic reconstruction are numerous and depend

Table 1.

Type of surgery	Pregnancies	Abortions	Ectopic pregnancies	Total pregnancies
Linear salpingostomy and salpingorrhaphy (13 cases)	At term 4 In evolution 2	1	1	8
Squeezing of the ovular sac (7 cases)	In evolution 2	—	1	3
Tubaric resection and termino-terminal anastomosis (2 cases)	At term 1	—	—	1

essentially on the site of implant and on the state of the tubaric wall at that moment ([1, 3, 4, 5, 7, 8, 9, 10]).

The conservative surgery can be resumed as follows:

1) Simple squeezing of the ovular sac in case of ampullar and fimbrial pregnancy.

2) Tubaric incision (linear salpingostomy plus salpingorrhaphy) in case of medio-tubaric pregnancy.

3) Tubaric resection and termino-terminal anastomosis, in case of medio-tubaric pregnancy with dilatation and thinning of the affected wall's tract.

4) Tubaric resection and reimplantation, in case of interstitial and istmic pregnancy.

MATERIAL AND METHODS

The 22 cases selected and treated by reconstructive plastic surgery, included only tubaric pregnancies diagnosed by laparoscopy, and in evolution. We have excluded on purpose the cases which came to our observation in advanced stages, with peritoneal shock, and with rupture or tubaric abortion. The age of our patients ranged between 18 and 29 years.

Five cases out of 22 already had one or more pregnancies, two had an abortion and four a previous ectopic pregnancy, while 11 were at their first pregnancy.

The conservative surgery was adopted considering the age and the desire of other pregnancies of the patient.

As reported in table 1, 13 patients underwent a linear salpingostomy followed by salpingorrhaphy in 7 cases.

Only two patients underwent a tubaric resection, followed by termino-terminal anastomosis, after excision of the affected tubaric tract.

The long-term results seem to be satisfactory: we have obtained pregnancies in 54.5% of the cases treated, with 40.9% fo a term or in evolution pregnancies (2nd, 3rd trimester), and 45.4% of intrauterine pregnancies.

Eight out of 13 patients treated by linear salpingostomy became pregnant, with 4 at term pregnancies, two pregnancies in evolution and one with abortion at the third month.

Three pregnancies (1 ectopic and 2 intrauterine in evolution) were obtained in the 7 cases treated by squeezing the ovular sac.

Two cases presented a relapse of tubaric pregnancy; one underwent squeezing of the ovular sac for an ampullar pregnancy, and one a linear salpingostomy.

In both cases we had to practice a demolitive surgery.

All pregnancies occured within 5 years from surgery.

During the months following surgery, the patients underwent utero-tubal insufflation, and hydrotherapy with hydrocortisone acetate.

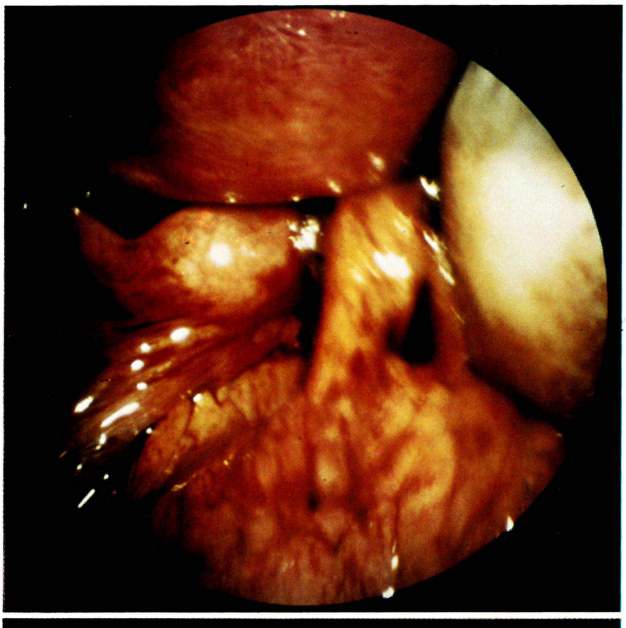
In 7 cases it has been possible an hysterosalpingographic control, which proved a normal post-surgical tubaric perviety.

CONCLUSION

By examining the results obtained, we can assert that the conservative surgery is indicated in all the cases in which it is possible to do such a type of surgery, after having evaluated the age, the desire of other pregnancies and the psychological factor of the patient, who is convinced to be "integral" under a procreative point of view.

Therefore we believe that, when it is possible, the fecondative potentiality must be respected since the modern diagnostic methods, the surgical techniques and the pharmacologic compounds, allow it.

We think that, for what concerns the possibility of a precocious laparoscopic diagnosis of tubaric pregnancy, at an ini-



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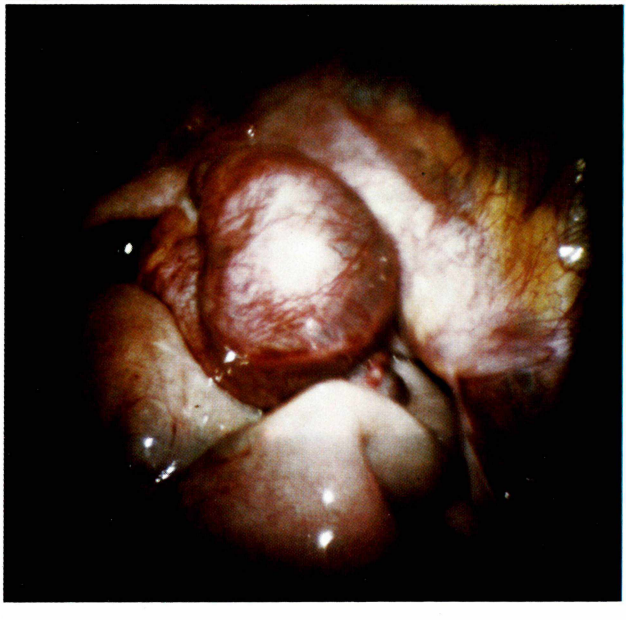

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Fig. 1. — Medio-tubaric pregnancy at the 5 th week of gestation.

Fig. 2. — Medio-tubaric pregnancy at the 7 th week of gestation.

tial evolutive stage, before that severe local anatomic alterations occur, these conservative surgical techniques allow to obtain the best results in restoring the anatomic and functional integrity.

Reports of new ectopic pregnancies, after a conservative treatment, are numerically few and they confirm the validity of our opinion, which considers valid a conservative and reconstructive mentality of the surgeon.

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