Ovarian ectopic pregnancy: a case report with review of literature

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Abstract

Background: Ectopic pregnancy is a major health issue in reproductive age group female. Incidence of primary ovarian ectopic pregnancy as mentioned in literature of India is variable from 0.001% to 0.014% of normal pregnancies. Only 0.15% to 3.0% of all ectopic pregnancy occurs in ovary and it is 2nd m/c site of ectopic pregnancy after fallopian tube. Annual incidence of extra uterine cavity pregnancy is rising over past 3 yrs. Aim and Objective: Aim of this review article is basically to describe a case of ovarian pregnancy and to study by a review of literature, the clinical sign & symptoms, diagnostic criteria and management of particular pathology accordingly, promote conservative surgical management. CASE-Here we report a case of 28 years old women, G5P3L3A1, presented to our hospital with lower abdomen pain with one and half month pregnancy with clinical feature of shock. Diagnosis was confirmed by transvaginal ultrasound, patient was prepared & taken for laparotomy in view of ruptured ovarian ectopic pregnancy. Her intraoperative findings were 200 cc hemoperitoneum present, salpingo-oophorectomy done on Rt side. Tubal ligation done on left side by modified pomeroy method. Postoperative period was uneventful. Her histopathological report shows ovarian tissue in wall of gestation sac. Conclusion: According to spiegelberg criteria, it is a diagnostic challenge to obstetrician. Diagnosis can be missed radiologically and intraoperatively. It Should be suspected in patients presented with ruptured ectopic pregnancy, ultrasound features suggestive of normal b/l fallopian tubewith hemoperitoneum with breached ovarian surface. Conservative surgical approach is preferred, Now days Medical management is preferred for unruptured ectopic pregnancy. Confirmation of ovarian pregnancy done only after histopathological report

Keywords: Ectopic pregnancy, Laprotomy, Salpingo-oophorectomy, Methotrexate

Introduction

The Incidence of ectopic pregnancy is 1.2 -1.4%. Incidence of primary ovarian ectopic pregnancy as mentioned in literature of India is variable from 0.001% to 0.014% of normal pregnancies. Only 0.15% to 3.0% of all ectopic pregnancy occurs in ovary and it is 2nd m/c site of ectopic pregnancy after fallopian tube [1]. Extra-iterine pregnancy or ectopic ovarian pregnancy a greek word originated from “EKTOPOS” which means out of place. Ektos refer to implantation of blastocyst outside of uterine cavity [1]. Primary ovarian ectopic pregnancy is very rare clinical presentation of extrauterine pregnancy & very dangerous life-threatening emergency if not diagnosed timely. Fallopian tube is most common site of ectopic pregnancy, comprises to 95% of total ectopic pregnancies. Incidence increasing with ART procedures and IUCD insertion. Ovarian pregnancy is gestational sac implantation in the ovary. First case of ovarian pregnancy is reported by St. Maurice in 1689. Its diagnosis is very difficult & based on clinical diagnosis, intraoperative finding and on histopathological report. Definite management of ruptured ovarian pregnancy is surgery. Approximately 75% pregnancies terminate in early gestation 12.5% patients terminates in the second trimester & 12.5% patients reached till term. Ovarian pregnancy in 1624, suggested first by Mercerus[2,3].

Incidence of ectopic pregnancy is-

1. Tubal pregnancy- 90-95.5%
2. Ovary-1.5- 3%
3. Abdomen-1.3%
4. Cervical -0.15%
5. Heterotopic 1-2%
6. Caesarean -6%
7. Interstitial -2.5%
Case Report

-28 years old female, she is G5P3A1 presented to our NIMS hospital emergency with complaints of amenorrhea of one and ½ months corresponds to 6 weeks and 3 days of gestation. According to patient her previous menstrual history was normal. There was no history of PID, ART procedure, Infertility treatment, Tuberculosis. On examination, vitals were BP-90/60 mm of Hg, PR-110 /min, clinical features suggestive of haemorrhagic shock were present. On P/A soft distension present and tenderness in RIF.P/V examination revealed –uterus mobile and non-tender, cervical motion tenderness present, 2.8x2.8 cm adnexal mass felt in right fornix.Patient investigated, her UPT +ve, Hb% 8gm, TLC 10,600/cumm, rest hemogram was normal, USG findings were uterine cavity Empty & bulky ET-19 mm, 2.8x2.8 cm with out fetal pole, freefluid was present in POD.

![Figure-1: Ultrasound showing ovauran ectopic pregnancy](image)

Our provisional diagnosis was ruptured ectopic pregnancy & patient was prepared for laparotomy, her intraoperative findings-

- Hemoperitoneum of 200 cc was present
- Uterus was bulky
- B/L fallopian tubes normal & left ovary normal
- Rt ovary enlarged with 2.8 x 2.8 cm size adnexal mass in situ, bluish red in color with bleeding from breached ovarian surface.

Right salpingo-ooporectomy done. Left side tubal ligation done by modified pomeroy’s method and tissue sent for histopathological examination. Her postoperative period was uneventful. Her histopathological report shows corpus luteum with trophoblastic villi in the ovarian tissue. Histopathological report of her D&C tissue shows absence of villous or fetal tissue.

![Figure 2: Intraoperative finding showing ovarian pregnancy](image)

Histopathology report & her intraoperative findings were satisfied with the Spigelberg criteria. Her immediate and long term postoperative course was uneventful. Patient followed up in OPD after 1 week of surgery. Her serial β hcg was on D5 -500miu/ml, D12 -30miu/ml, D19- undetectable.
Discussion and Review of Literature

Clinical presentation of primary ovarian ectopic pregnancy is variable. This is a life-threatening emergency. Etiology of ovarian ectopic pregnancy still remain obscure. A study done by goyal et. al concluded that incidence of ovarian pregnancy is 4.8% of all pregnancies. 94% patients diagnosed in first trimester, in 11% cases preoperatively diagnosed only [3,4]. Increase incidence with ART procedures [due to increase progesterone from corpus luteum, ovarian hyper vascularity due to hyper stimulation], PID, previous pelvic surgery, PCOD, fibroid uterus. IUCD is found in 15-32% of patients of non ovarian ectopic pregnancy. 60-92% of patient of ovarian ectopic pregnancy. Grimes et. al studied 24 case of ovarian pregnancy & concluded greater then 50% cases had infertility or failed ART(4,5).

Cigarette smoking also interferewith tubal motility and ovum pickup. There is usually delay in diagnosis because Gestation sac of ovarian ectopic pregnancy in ultrasound mimic to haemorrhagic cyst of ovary, corpus luteal cyst, endometrioma of ovary. Diagnosis confirmed by TVS and CT scan. Ovarian pregnancy carries higherriskof morbidity and mortality then tubal pregnancies because ovarian pregnancy located at the most vascularised site of female pelvis. Uteroovarian anastomosis of blood vessels eroded by developing chorionic villi, leads to severe haemorrhage and patient went into haemorrhagic shock [6,7].

Ovarian ectopic pregnancies diagnosed intraoperatively &histo-pathologically fewexceptions according to spigelberg criteria. ovarian ectopic pregnancy should be differentiated from ampullary /infundibulam tubal pregnancy, in these cases ovaries may involve secondarily after tubal abortion or rupture [8].

Criteria includes:
1. Gestation sac should occupy the normal position of the ovary.
2. Gestation sac and uterus connected with each other by utero-ovarian ligament.
3. Affected side fallopian tube with its fimbria should be intact andseparate from ovary.
4. Ovarian tissue (tunica albugenia) must be present in the specimen or in the wall of gestational sac.
5. Empty uterine cavity and evidence of amniotic cavity within follicle.

3D ultrasound (TVS) help to differentiate from haemorrhagic corpus luteal cyst (8).Diagnostic features of ovarian pregnancy are -

Sensitivity is 85%-92% and specificity is 99.98%

1. Double echogenic ring found within hypoechoic latero-uterine mass &echogenecity of ring is more then ovary itself (inhomogenous mass). Wideechogenic ring with an internal echolucent areas on superficial ovarian surface are also found.
2. Gestational sac found very adjacent to the ovary.
3. All around mass follicles & corpus luteum is present as a part of ovarian cortex.
4. Empty uterine cavity & free fluid in peritoneal cavily.(mild fluid in pod is physiological)
5. Ovarian ectopic pregnancy will move with ovary on pressure applied with transvaginal probe.

Gestation sac visualizedby trans-abdominal scan at β-hCG discriminatory zone ≥6500miu/ml in 1981. Discriminatory zone for Transvaginal ultrasound upto 1000 to 2000 miu/ml. Com shock et. al studied ultrasonographic appearance of ovarian ectopic pregnancy and they concluded ovarian pregnancyis rarely identified correctlyby sonographyandit is eververy difficulit to diagnose intra operatively [8,9]. Ectopic pregnancy may coexist with an intrauterine pregnancy but it is very rare with incidence 1/40000, diagnosis is very difficult. It is common with assisted conception. Benauerleaf et. al suggested that transducer frequency from 7MHZ to 10MHZ is helpfull in improving diagnostic accuracy [9].

Ovarianectopic pregnancy classifiedinto two types –

1. Intral follicular pregnancy- In this ovum trapped inside the follicle, mature ovum not picked up or expelled from its follicle. Sperm fertilizethe egg after entering into follicle various theories are given for explanation
   ➢ Hormonal causes
   ➢ Thickened tunica albugenia of the ovary
   ➢ Defect in ovum pick up due to inadequate fimbria on ovarian surface
2. Extra follicular pregnancy—mature ovum fertilized outside of ovary, implant on ovariansurface because of endometrial decidual reaction.

Fe why potheses suggested, Inflammatory thickened tunica albugenia and malfunctioning of tubes. Interference of release of mature ovum from follicle.

The sign and symptom of primary ovarian pregnancy are very similar to tubal ectopic pregnancy. Very difficult to differentiate clinically from chocolate cyst, haemorrhagic cyst, tubal pregnancy.

Trophoblastic cells invade the ovarian tissue on 6th day, followed by the invasion of the ovarian artery. Although ovarian pregnancies rupture by the 40th gestational day, reports of those progressing into the 3rd trimester even to live births have been established.

Most of primary ectopic pregnancy usually ruptured in first trimester of pregnancy. Recurrent ectopic pregnancy is not reported yet, in contrast totubal pregnancy, 15% recurrence noted in primigravida patients. A study done by Savita et al. according to them out of 104 patients only 94 patients had ectopic proved by histopathology and remaining had either haemorrhagic cyst or corpus luteal hematoma. Out of 94 patients only four had ovarian pregnancy who fulfilled spigelberg criteria.

Future fertility after surgery is unaffected- Goyal et al. done aretrospective cross – sectional study on ovarian pregnancy at Government medical college & hospital Chandigarh, they studied risk factor, incidence, diagnosis and management of ovarian pregnancy [3,10].

Table No- 1: Risk factor for ovarian pregnancy.

| S. No | Age | POG-weeks | O/H | Past history | USG finding | Management |
|-------|-----|-----------|-----|--------------|-------------|------------|
| 1     | 22  | 9 wk      | G4P2L2A1 | IUCD-3yr     | FF in POD   | Excision of sac & B/L salpingectomy |
| 2     | 24  | G1        | 1* infertility | FF in POD | Excision of sac & B/L salpingectomy |
| 3     | 25  | 7wk       | G5P2L2A2 | IUCD-2yr     | B-hCG-2000  | Excision of sac & B/L salpingectomy |
| 4     | 26  | Nil       | P4L4 | IUCD-5yr     | 4×4cm, hernal | Oopherectomy |
| 5     | 23  | 36wk      | G3P2L2  | MTP          | Placenta previa | Laproscopy with Excision of placenta delivery of baby and oopherectomy |
| 6     | 34  | 8wk       | G3P1L1A1 | --           | FF in POD, B-hCG-1800 | Excision of sac & repair |
| 7     | 23  | 9wk       | G2A1 | --           | Lt adnexal mass, FF + | Lt oopherectomy |
| 8     | 36  | 6wk       | G4P3L3 | IUCD-5yr     | Lt ovary G. Sac, B-hCG-2000 | Excision of sac |
| 9     | 25  | 7wk       | G1    | Infertility  | FF in POD   | Excision of sac |
| 10    | 7   | Nil       | P3L3 | --           | Lt adnexal mass B-hCG-3000 | Excision of sac & repair |

A study done by Savita et al. They concluded out of 4 patient 3 patient had history of risk factor like IUCD was present.

Management- Expectant management-Success rate is 48%-100%.

Inclusion criteria –

- Asymptomatic women with stable vitals
- B-hCG<1000miu/ml
- Ultrasound findings – Size ≤ 2cm and GA < 6 weeks, Cardiac activity absent, YoIk sac and fetal pole also absent, Free fluid in pouch of douglas <100CC.
- Serum progesterone level <3.1 ng/ml
- Cooperative patient willing for follow up
These patients followed twice weekly on Day 3, 7.

1. If β-hCG fall >50% within a week, continue expectant management.
2. If β-hCG fall <50% within a week, consider medical/surgical management.

It is most useful when initial β-hCG level is ≤1000 IU/l with unruptured ectopic pregnancy. Success rate is b/w 50-80%. According to a prospective observational study, 118 patients are on expectant management. Out of them 88% recovered successfully. They had β-hCG ≤ 200 mIU/mL and patients with β-hCG level ≥ 2000 mIU/mL only 26% recovered. Favorable factors for success of expectant management are serum β-hCG level ≤ 200, gestational age ≤ 6 weeks & progesterone level below 10 nmol/L.

Expectant management to be stopped if the patient is having if the β-hCG level increases or persistently increasing abdominal pain. To avoid rupture of ectopic pregnancy, patient should instruct to avoid vigorous physical activity, sexual activity & pelvic examination.

**Medical Management** - Mittal et al. first-time used injection methotrexate directly into gestational sac of ovary [11]. Kudo et al. reported first successful use of methotrexate in ovarian pregnancy. Gabbur et al. Done a retrospective analysis on MTX use in unruptured ovarian ectopic and concluded that after single MTX injection on D7 β-hCG levels only, predict an need of surgery or successful treatment not Day 4 β-hCG level [10,11].

Patient selection is very important. Methotrexate is antagonist of folic acid that impairs cell replication & DNA synthesis. In 1982 first time used for medical management and mode of action by killing rapidly dividing cytotrophoblasts cells at implantation [11,12].

**Table No-2: Contraindication of Methotrexate treatment in ectopic pregnancy.**

| Absolute | Relative |
|----------|----------|
| i. Hypersensitivity | i. β-hCG > 5000 mIU/ml |
| ii. Thrombocytopenia (< 1 lac/µl) | ii. Ectopic mass > 4 cm |
| iii. Liver dysfunction > 2 fold. Alcoholic liver diz. | iii. Fetal cardiac activity present |
| iv. Pulmonary and peptic ulcer disease | iv. Poor complaint patient |
| v. Hematological dysfunction with bone marrow depression TLC < 1500/µl | |
| vi. Heterotopic pregnancy | |
| vii. Ruptured ectopic pregnancy | |
| viii. Lactating mothers | |
| ix. Moderate to severe anemia | |
| x. creatinine clearance < 50 mL per minute per 1.73 m² | |

Patient should instruct to stop taking prenatal vitamins, Alcohol, nonsteroidal anti-inflammatory drugs & avoid excessive sunlight (to avoid MTX induced dermatitis) and folate supplementation, as folate will counteract action of injection methotrexate. Rh status of patient must be known to determine further need of immunoglobin therapy in Rh negative patient. A meta-analysis on single and multiple dose regimens done by Barnhart et al. They concluded multidose regimen is more effective (90%) than single dose (80%) [13,14,15].

If β hCG is ≥ 5000 treatment failure rate is 40%. If 15% decrease occurs b/w Day 4 and Day 7, β-hCG levels monitored weekly till reach zero. This will take at least five to seven weeks.

**Single dose of methotrexate** - Levin et al. done a study and concluded, out of 69 women of study group 45 patient was treated successfully with single dose of injection methotrexate. Before single dose of methotrexate good predictor of successful treatment are-

If β-hCG level ≤ 1600 IU/l and increase ≤14%, in a day or 24 hr.

Single dose regimen associated least side effects.
Table No.- 3: Single dose of methotrexate treatment protocol.

|   | 0 | 4 | 7 |
|---|---|---|---|
| 1. Investigations | Bhcg, CBC, ABO Rh, LFT, RFT | Bhcg | Bhcg |
| 2. Medical management | Methotrexate in dose of 50mg/m² of body surface area is given by IM route | Methotrexate in dose of 50mg/m² of body surface area is given by IM route | i. If Decrease in βhcg >15% between from day 4 to day 7. Monitor βhcg weekly till zero. |

Two dose regime of methotrexate of ectopic pregnancy- Branhart was only one who first described “Double dose regimen”. Hossam et al. concluded that double dose protocol is better than single dose regimen [16,17].

Table No-4: Multiple dose of methotrexate treatment protocol.

|   | 0 | 4 | 7 | 11 | 14 |
|---|---|---|---|----|----|
| Investigations | CBC, ABO Rh, LFT, RFT, βhcg | Bhcg | Bhcg | Bhcg | Bhcg |
| Medical management | Methotrexate in dose of 50mg/m² of body surface area is given by IM route. | If Decrease in βhcg >15% between from day 4 to day 7. Monitor βhcg weekly till zero. | If βhcg decrease <15% between day 4 to day 7. Give methotrexate. | If Decrease in βhcg >15% between from day 7 to day 11. Monitor βhcg weekly till zero. | If βhcg decrease <15% between day 7 to day 11. Give methotrexate. |

Multiple dose regime of methotrexate in ectopic pregnancy- Krik et al. concluded that multiple dose regimen is more effective than single and double dose protocol with sensitivity 94%, specificity 86% [1,17,18].

Table No-5: Double dose of methotrexate treatment protocol.

|   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Investigations | CBC, AB Rh, RFT, LFT, β Hcg | β hcg | β hcg | LEU | LEU | LEU | LEU | LEU |
| Medical management | Methotrexate to be given by 1mg/kg by IM route | Leucovorin to be given by 0.1mg/kg by IM route | If Decrease in βhcg >15% between from day 1 to day 3. Monitor β hcg weekly till zero. | If βhcg decrease <15% between day 1 to day 3. Give methotrexate. | If Decrease in βhcg >15% between from day 3 to day 5. Monitor β hcg weekly till zero. | If βhcg decrease <15% between day 3 to day 5. Give methotrexate. | If Decrease in βhcg >15% between from day 5 to day 7. Monitor β hcg weekly till zero. | If βhcg decrease <15% between day 5 to day 7. Give methotrexate. |

Success rate of treatment with β- hCG ≤1000miu/ml is 87%. Failure rate is 40% with level ≥5000miu/ml.
Surgical Management- Primary management of Ovarian ectopic pregnancy is surgical. According to 3 prospective randomized trial laparoscopic approach is superior then laparotomy in view of less blood loss & pain, shorter hospital stays and there is no significant difference in recurrence, subsequent intrauterine pregnancy [17,18]. Laparoscopic surgery has become preferred method & gold standard nowadays. Conservative surgical technique like ovarian wedge resection, enucleation are also in trend now days. 80% cases managed by conservative management and radical oophorectomy done in 13% cases only. John et al. Was performed first laparotomy for ovarian ectopic pregnancy in 1759. In 1884 Robert et al. Ligated bleeding vessels first time during laparotomy [4]. Shapiro and Adler introduced first time a laparoscopic approach in 1973 [20,21]. According to Cochrane review 2007, there is no significant difference b/w systematic methotrexate and conservative surgery if β-hCG level ≤1500 miu/ml. Corpus lutectomy for trophoblast, curettage of trophoblast by coagulation and hemostatic suture of the bed. These are totally conservative surgeries. In case of advanced ectopic pregnancy oophorectomy or ovariectomy [22,23,24]. Recurrence of ovarian pregnancy in literature till now. Only single case reported has been reported in contrast to tubal ectopic pregnancy recurrence rate is up to 15% [25-29].

Conclusion and Perspective

According to spigelberg criteria, it is a diagnostic challenge to obstetrician. Diagnosis can be missed radiologically, intraoperatively. Ovarian pregnancy can occur even in Nulliparous female without risk factors like IUCD, PID, ART. Now days Medical management with single dose of Methotrextate is very successful for unruptured ovarian pregnancy. Should be suspected inpatients presented with ruptured ectopic pregnancy, ultrasound features suggestive of normal b/l fallopian tube with hemo-peritoneum with breached ovarian surface. Conservative surgical approach is preferred. Confirmation of ovarian pregnancy done only after histo-pathological report.

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References

1. Aetiology, diagnosis, and challenges in surgical management. J Obstet Gynaecol. 2012;32:472–4,2012.
2. Poonam Rana, Imran Kazmi, Rajbala Singh, Muhammad Afzal. Ectopic pregnancy: a review. Arch Gynecol Obstet. 2013; 288: 747–75,2013
3. Krik E, Bourne T. Ectopic pregnancy. Obstetgynecol Reprod Med 2011;21:207-211,2011.
4. Goyal Lajya Devi, M.D.,1Tondon Rimpy, M.D., 2 Goel Poonam, M.D.,2 and Sehgal Alka, M.D. Ovarian ectopic pregnancy: A 10 years’ experience and review of literature. Iran J Reprod Med. 2014 December; 12 (12) : 825–830, Dec 2014.
5. Fritz MA, Speroff L. Clinical gynecologic endocrinology and infertility, 8th edn. Wolters Kluwer Health/ Lippincott Williams & Wilkins, Philadelphia. 2011.
6. Hallatt JG. Primary ovarian pregnancy: a report of twenty-five cases. Am J Obstet Gynecol. 1982;143:55–60, 1982.
7. Panelli Danielle M, H. Phillips Catherine, Brady Paula C, Incidence, diagnosis and management of tubal and nontubal ectopic pregnancies: a review. Fertility Research and Practice 2015; 1:15,2015.
8. Vanitha N Sivalingam, W Colin Duncan; Emma Kirk, Lucy A Shephard, Andrew W Horne. Diagnosis and Management of Ectopic Pregnancy. J Fam Plann Reprod Health Care. 2011;37(4):231-240,2011.
9. Comstock C, Huston K, Lee W. The ultrasonographic appearance of ovarian ectopic pregnancies. Obstet Gynecol. 2005;105:42–45,2005.
10. Chang FW, Chen CH, Liu JY. Early diagnosis of ovarian pregnancy by ultrasound. Int J Gynecol Obstet. 2004; 85:186–187,2004.
11. Juan YC, Wang PH, Chen CH, Ma PC, Liu WM. Successful treatment of ovarian pregnancy with laparoscopy-assisted local injection of etoposide. FertilSteril. 2008;90:1200, 2008.
12. Mittal S, Dadhwal V, Baurasi P. Successful medical management of ovarian pregnancy. Int J Gynecol Obstet. 2003; 80:309–310,2003.
13. Buster JE, Carson SA. Ectopic pregnancy; new advances in diagnosis and treatment. Curr Opinion Obstet Gynecol. 1995; 7:168–176,1995.
14. Gabbur N, Sherer DM, Hellmann M. Do serum beta-human chorionic gonadotropin levels on day 4
following methotrexate treatment of patients with ectopic pregnancy predict successful single-dose therapy? Am J Perinatol. 2006. 23: 193–196, 2006.

15. Barnhart KT, Gosman G, Ashby R, Sammel M. The medical management of ectopic pregnancy: a meta-analysis comparing “single dose” and “multidose” regimens. Obstet Gynecol. 101:2003;778–784,2003.

16. Barnhart K, Hummel AC, Sammel MD, Menon S, Jain J, Chakhtoura N. Use of “2-dose” regimen of methotrexate to treat ectopic pregnancy. Fertil Steril. 2007; 87:250–256, 2007.

17. Hossam O, Hamed A, Salah R, Ahmed A, Abdullah A. Comparison of double- and single-dose methotrexate protocols for treatment of ectopic pregnancy. AlghashamInt J Gynecol Obstet.2012; 116:67–71, 139, 2012.

18. Kirk E, Condous G, Van Calster B. A validation of the most commonly used protocol to predict the success of single-dose methotrexate in the treatment of ectopic pregnancy. Hum Reprod. 2007;22:858–863,2007.

19. Bagga R, Suri V, Verma P, Chopra S, Kalra J. Failed Medical Management in Ovarian Pregnancy Despite Favorable Prognostic Factors-A Case Report. Med Gen Med. 2006;8:35,2006.

20. Habbu J, Read MD. Ovarian pregnancy successfully treated with methotrexate. J Obstet Gynaecol. 2006;26: 587–8, 2006.

21. Shapiro HI, Adler DH. Excision of an ectopic pregnancy through the laparoscope. Am J Obstet Gynecol. 1973;117:290–1.

22. Ayakannu T, Rogers J, Wordsworth S, Jayagopal N, Vine S. Conservative laparoscopic approach with systemic medical management of an ovarian ectopic gestation. J Obstet Gynaecol. 2007;27:449–50,2007.

23. Mittal S, Dadhwal V, Baurasi P. Successful medical management of ovarian pregnancy. Int J Gynaecol Obstet. 2003;80:309–10,2003.

24. O. Birge, M. M. Erkan, E. G. Ozbey, and D. Arslan, “Medical management of an ovarian ectopic pregnancy: a case report,” Journal of Medical Case Reports., 2015; vol. 9:1, article no. 774.,2015.

25. G. Scutiero, P. Di Gioia, A. Spada, and P. Greco, “Primary ovarian pregnancy and its management,” Journal of the Society of Laparo-endoscopic Surgeons. 2012; vol. 16;3,492–494,2012.

26. Y. Koo, H. Choi, K. Im, H. Jung, and Y. Kwon, “Pregnancy outcomes after surgical treatment of ovarian pregnancy,” International Journal of Gynecology & Obstetrics. 2011; vol. 114; 97–100, 2011.

27. Chatburn Luke, SanghaniReesha, Chatburn Luke, et al. An Alternative Treatment for the Ovarian Ectopic Pregnancy. J Womens Health Gyn.2015;Vol2:102, 2015.

28. Joseph RJ, Irvine LM. Ovarian ectopic pregnancy: Odejinmi F, Rizzuto MI, Macrae R, Olowu O, Hussain M. Diagnosis and laparoscopic management of 12 consecutive cases of ovarian pregnancy and review of literature. J Minim Invasive Gynecol. 2009;16:354–9, 2009.

29. Nadarajah S, Sim LN, Lo SF. Laparoscopic management of an ovarian pregnancy. Singapore Med J. 2002; 43:95–6,2002.

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