Case report

Death due to Ruptured Ectopic Pregnancy
Natural Death or Negligence?

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Abstract

A young adult female of low socio-economic status, and a labourer by profession, was brought dead to the Government Medical College & hospital, Chandigarh. History provided by her husband revealed that she had pain abdomen for the last five days for which she was getting treatment from a private practitioner. She had been prescribed NSAIDs and antispasmodics for the same. However, she was not investigated upon and no attempt was made by the practitioner to arrive at any diagnosis. The autopsy was conducted on the next day and at autopsy, about two-and-a-half liters of blood was present in the abdomen and pelvic cavity. Careful internal examination revealed a ruptured ectopic pregnancy as the source of bleeding. The case is discussed with regard to establishing whether the death could have been natural, due to the negligence of the treating doctor or due to contributory negligence. However, even in cases of contributory negligence, the “last chance doctrine” may not save the physician.

Key Words: Ectopic Pregnancy, Ruptured Ectopic Pregnancy, Pain Abdomen, NSAIDS, Negligence, Contributory Negligence

Introduction:

Ectopic pregnancy occurs when a fertilized egg implants outside of the uterine cavity. One out of every 100 pregnancies is ectopic with the most common site being within a fallopian tube. [1]

More rarely an embryo may implant within an ovary, in the cervix, or on the abdominal wall or caesarian scar. Although the fertilized egg is not cradled within the uterus, the embryo continues to grow and expand. Without treatment, the fallopian tube can rupture and can cause serious problems and sometimes death, as in this case. The most common risk factors for ectopic pregnancy are pelvic inflammatory disease (PID), misshapen tubes, endometriosis, surgery on a tube such as tubal ligation done to prevent pregnancy, adhesions from prior surgery, history of infertility, an earlier ectopic pregnancy, an intrauterine device (IUD), a pelvic mass like a fibroid, increasing age, smoking, etc. [1-4]

Clinicians should consider the diagnosis of ectopic pregnancy in any woman in the child-bearing age with history of secondary amenorrhea and who has abdominal or pelvic pain, vaginal bleeding, or both.[5] Only 50% of patients present with the classic clinical triad of ectopic pregnancy i.e., pain, amenorrhea, and vaginal bleeding.[6] Other symptoms common to early pregnancy like nausea, breast fullness, fatigue, low abdominal pain, heavy cramping, shoulder pain, and recent dyspareunia may also be present. A high index of suspicion in patients presenting with the above symptoms and with physical findings of pelvic irritation or tenderness, an enlarged uterus or an adnexal mass helps the clinician in considering the diagnosis of a ruptured ectopic pregnancy.

Fortunately, using modern diagnostic techniques, most ectopic pregnancies can be diagnosed prior to rupturing.

Case:

Dead body of a 25-year-old woman of low socio-economic status, and a labourer by profession, was brought to the hospital mortuary for post mortem examination. History, as per the police and her husband revealed that she had pain abdomen for the last 5 days for which she was taking treatment from a local private practitioner. She was prescribed pain killers along with antacids, apparently without any investigations. Her condition worsened on the fourth day, when she reported to the same doctor. This time, she was given another pain killer along with Tab Buscopan™ (antispasmodic) (German Remedies, India) and was advised strict bed rest. She was,
however neither investigated nor advised admission. On the very next day the condition deteriorated significantly, the lady became unconscious and then the same treating doctor was called who, after examining her advised the husband to shift the patient immediately to the GMCH hospital. She was declared brought dead to the emergency. The body was shifted to the mortuary and the postmortem examination was conducted the next day.

**Autopsy Findings:**

The body was that of a young adult female, rigor mortis was present all over and faint post mortem staining was present and fixed over back. Eyes were closed, corneas were hazy, conjunctiva pale and generalized pallor was present over the body. There were no signs of decomposition. No injuries were present on the body on external examination. Internal examination showed presence of about 2.5 liters of blood in the abdomen and pelvic cavity. On careful internal examination, a ruptured ectopic pregnancy of size 1 cm × 1 cm was found on the left fallopian tube at its isthmus. The ectopic had eroded the uterine artery. The uterine cavity was empty with slightly thickened walls, and corpus luteum was present in the left ovary. All other internal organs were pale. Histopathology of the fallopian tube and the mass confirmed the presence of products of conception.

**Discussion:**

Ectopic pregnancy occurs when a fertilized egg implants outside of the uterus cavity. One out of every 100 pregnancies is ectopic with the most common site being within a fallopian tube. [1]

More rarely an embryo may implant in the cervix, on an ovary, on the spleen or liver, in the cul-de-sac, on the abdominal wall or within the broad ligament. [7] Although the fertilized egg is not cradled within the uterus, the embryo continues to grow and expand. Without treatment, the fallopian tube can rupture and can cause serious problems and sometimes death, as was in this case. The most common risk factors for ectopic pregnancy are pelvic inflammatory disease (PID), misshapen tubes, endometriosis, surgery on a tube such as tubal ligation done to prevent pregnancy, adhesions from prior surgery, history of infertility, an earlier ectopic pregnancy, an intrauterine device (IUD), a pelvic mass like a fibroid, increasing age, smoking, etc.[1,7-10] The highest rate of ectopic pregnancy occurs in women aged 35-44 years.[11] A three to four-fold increase in the risk for developing an ectopic pregnancy exists in this age group compared to women aged 15-24 years. One proposed explanation involves the myoelectrical activity in the fallopian tube, which is responsible for tubal motility. Ageing may result in a progressive loss of myoelectrical activity along the fallopian tube. [11]

Clinicians should consider the diagnosis of ectopic pregnancy in any woman in the child-bearing age with history of secondary amenorrhoea and who has abdominal or pelvic pain, vaginal bleeding, or both.[12] Only 50% of patients present with the classic clinical triad of ectopic pregnancy i.e., pain, amenorrhea, and vaginal bleeding.[11] Other symptoms common to early pregnancy like nausea, breast fullness, fatigue, low abdominal pain, heavy cramping, shoulder pain, and recent dyspareunia may also be present. A high index of suspicion in patients presenting with the above symptoms and with physical findings of pelvic irritation or tenderness, an enlarged uterus or an adnexal mass helps the clinician in considering the diagnosis of a ruptured ectopic pregnancy.

However only 40-50% of patients with an ectopic pregnancy present with vaginal bleeding, 50% have a palpable adnexal mass and 75% may have abdominal tenderness. [12] Approximately 20% of patients with ectopic pregnancies are hemodynamically compromised at initial presentation, which is highly suggestive of rupture.[11] Fortunately, because of the modern diagnostic techniques, most ectopic pregnancies can be diagnosed prior to rupturing.

According to a study by Lewis, ectopic pregnancy was one of the most important causes of death in early pregnancy. A significant number of these early pregnancy deaths were in women who were discharged from the primary care setting (either general practice or emergency department) having never had a pregnancy test or misdiagnosed with gastroenteritis.[13] The present case was similar in the sense that it was misdiagnosed as a case of gastroenteritis / gastric complaints.

Approximately 10-15% of tubal ectopic pregnancies resolve spontaneously.[14-16] In the present case, due to irresponsible and careless diagnosis and wrong prescription of drugs, the lady was robbed of her chance of spontaneous cure.

No efforts were made by the doctor in the present case to diagnose or rule out pregnancy; moreover, history was not elicited with regard to amenorrhea, irregular vaginal bleeding, or sexual activity. Treatment was given only on the lines of pain abdomen due to gastrointestinal disturbances, which is the most common mistake done by the treating doctor (either in general practice or in the emergency department). Suspicion of pregnancy and subsequent possibility of a tubal pregnancy could have saved the life of the woman. Any of the following could have been done to rule out pregnancy – simple urine pregnancy test, serum pregnancy test, pregnancy ultrasound,[17-21] putting a needle into the abdomen through the posterior
vaginal fornix to tap any leaking blood from a ruptured ectopic pregnancy or laparoscopy.[21-25] Instead, on the patient complaining of worsening of the pain, she was prescribed a stronger pain killer with an antispasmodic which could have, and in this case, must have caused more bleeding from the ruptured ectopic pregnancy, as a result of relaxation of the affected tissues, due to which she passed into shock and expired on the way to hospital. The husband of the deceased never pressed charges of negligence on the doctor, either due to poverty, illiteracy, ignorance or absence of support from the police.

It can also be argued here that the case could fall in the category of contributory negligence on account of the patient not giving the history of pregnancy. This argument may hold water if the knowledge of the patient regarding pregnancy can be proved along with the fact that the doctor had indeed made an attempt to rule out pregnancy before managing the case as one of gastrointestinal disturbance. However, the “last chance doctrine” may not save the physician in such a case.

References: