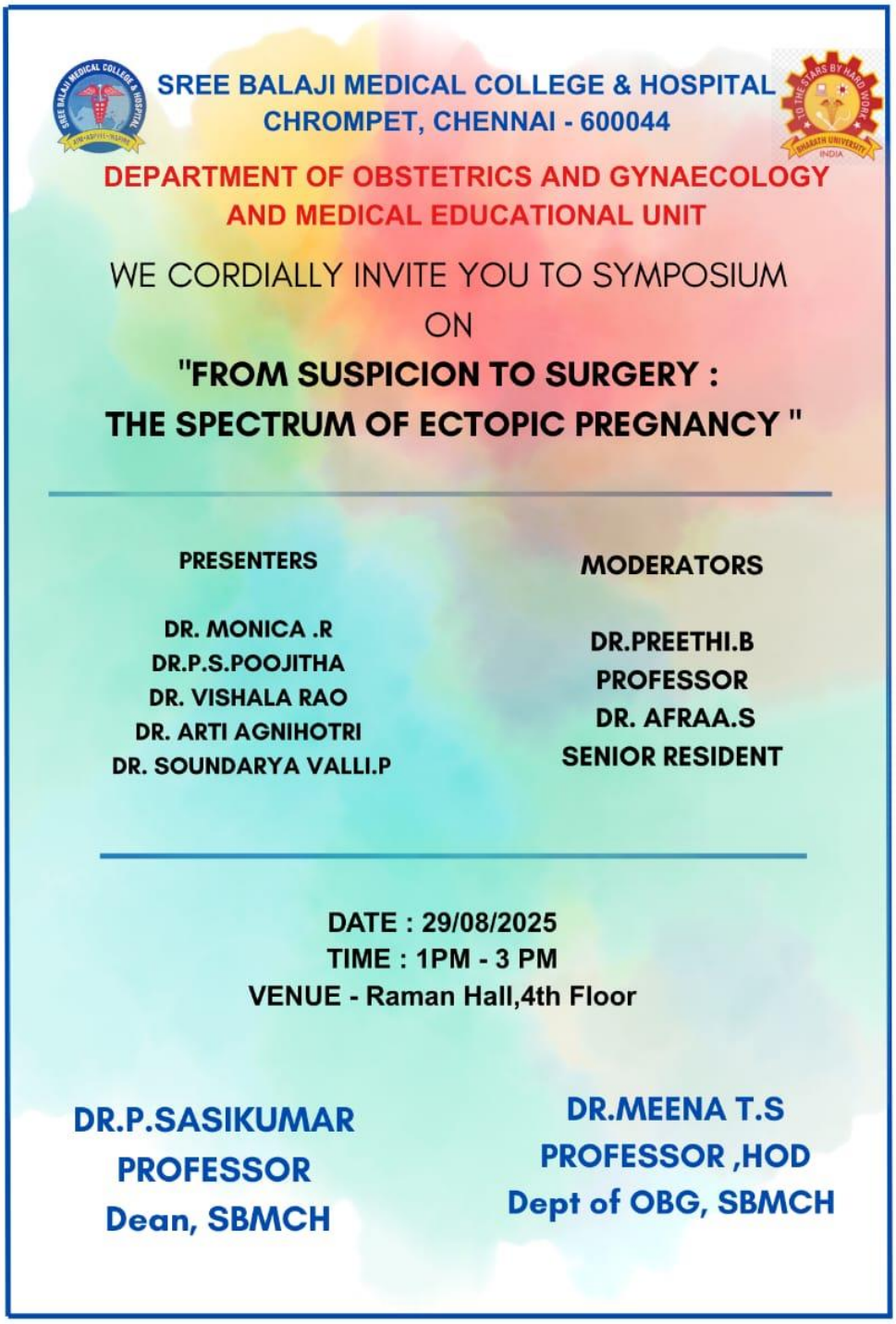


PG SYMPOSIUM

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY 29/8/25

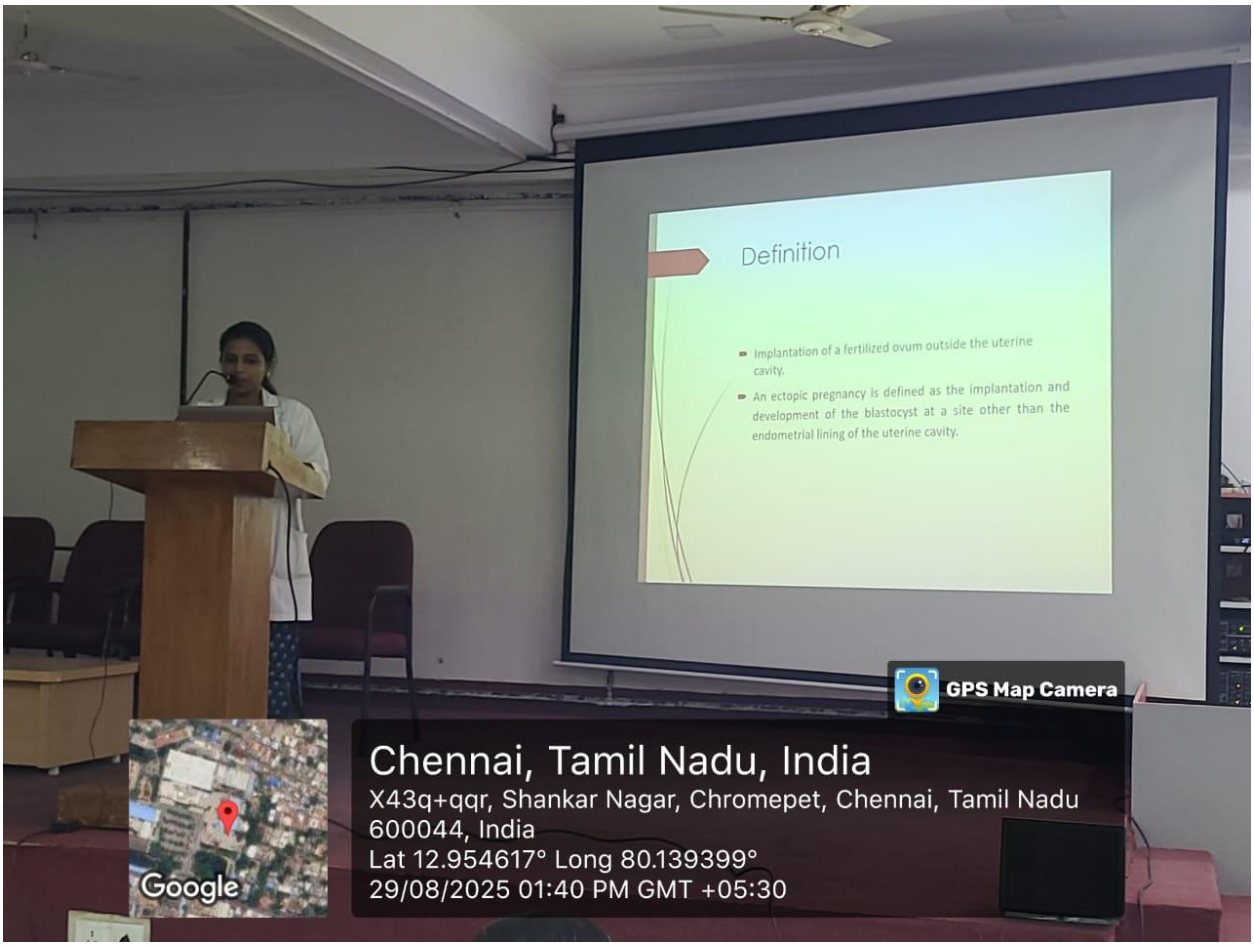
Presenter 1

TOPIC- INTRODUCTION TO ECTOPIC PREGNANCY

SPEAKER - Dr.MONICA .R

Second year postgraduate

Department of OBG



SUMMARY:Ectopic pregnancy is the implantation of a fertilized ovum outside the uterine cavity, most commonly in the fallopian tube (ampullary, isthmic, fimbrial, or interstitial), though it may also occur in the ovary, cervix, abdominal cavity, or cesarean

scar. The condition arises due to impaired tubal transport or abnormal implantation, often associated with risk factors such as pelvic inflammatory disease, previous ectopic pregnancy, tubal or pelvic surgery, infertility, assisted reproductive techniques, intrauterine device use, smoking, advanced maternal age, and endometriosis. Pathologically, the developing trophoblast invades the tubal wall, leading to thinning, congestion, and hemorrhage; villi and decidual reaction may be seen in the tube. As the conceptus grows, the tube cannot accommodate the gestation, predisposing it to rupture or tubal abortion, which can result in life-threatening intra-abdominal bleeding.

Presenter 2

SPEAKER – DR.POOJITHA

Second year postgraduate

Department of OBG

TOPIC : UNRUPTURED ECTOPIC PREGNANCY

Unruptured tubal ectopic pregnancy is a potentially life-threatening condition where the fertilized ovum implants in the fallopian tube, most often in the ampullary region. Advances in transvaginal ultrasonography and quantitative serum β-hCG testing have enabled earlier diagnosis, allowing conservative and fertility-preserving treatment before rupture. Diagnosis relies on clinical suspicion supported by serial β-hCG assays and transvaginal ultrasound, with absence of intrauterine pregnancy and presence of an adnexal mass or abnormal β-hCG trends being key indicators. Additional tests such as serum progesterone, complete blood count, and Rh typing help guide management. In hemodynamically stable women, systemic methotrexate is the treatment of choice for appropriately selected cases—small adnexal mass, no fetal cardiac activity, and β-hCG <5000 mIU/mL—achieving high success rates while preserving tubal function, whereas surgery is reserved for contraindications, failed medical therapy, or unstable presentations.

Presenter 3:

SPEAKER – DR.VISHALA

Second year postgraduate

Department of OBG

TOPIC : RUPTURED ECTOPIC PREGNANCY

The presentation discusses ruptured ectopic pregnancy with a focus on clinical suspicion, diagnosis, pathophysiology, and management. It outlines the classical triad of amenorrhea, abdominal pain, and vaginal bleeding—often accompanied by shock—and emphasizes that diagnosis is primarily clinical, supported by ultrasound and hCG when feasible. Management prioritizes resuscitation and surgical intervention (usually salpingectomy), with guidelines from RCOG, ACOG, and NICE recommending immediate laparotomy in unstable patients and laparoscopy when stable. It also reviews intraoperative steps, postoperative care including Anti-D and counseling, and explores related entities like tubal abortion (expulsion of the conceptus through the fimbrial end) and chronic ectopic pregnancy (low-grade, persistent implantation with organized hemoperitoneum), highlighting their diagnostic challenges and tailored management approaches.

Presenter 4

Dr. Arti Agnihotri

Second year post graduate

Dept of obg

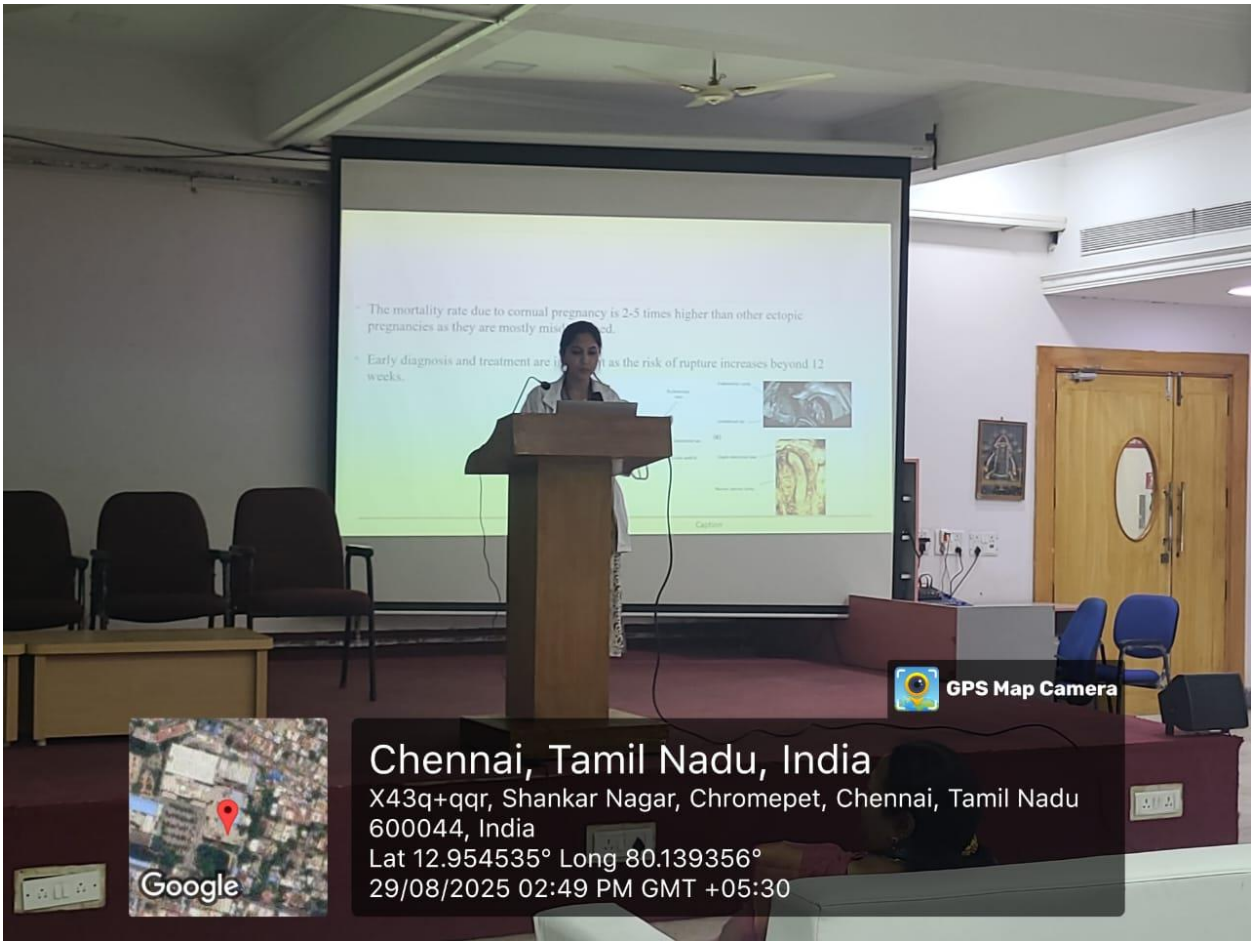
ABDOMINAL ECTOPIC PREGNANCY

INTERSTITIAL, OVARIAN, CERVICAL ECTOPIC PREGNANCY

The presentation outlines rare forms of ectopic pregnancy beyond the common tubal type, including **interstitial, cervical, abdominal, and ovarian ectopic pregnancies**. Interstitial pregnancy, though only 2–4% of cases, carries high risk due to delayed rupture and massive hemorrhage; diagnosis relies on ultrasound criteria such as the interstitial line sign, and management may involve methotrexate or surgical cornual

resection. Cervical pregnancy presents with painless heavy bleeding, diagnosed by ultrasound and criteria like those of Paalman & McElin, with management ranging from methotrexate and uterine artery embolization to hysterectomy if bleeding is uncontrollable. Abdominal pregnancy is rare but dangerous, diagnosed using Studdiford's criteria and imaging, with management focused on cautious fetal delivery and careful handling of the placenta to avoid fatal hemorrhage. Ovarian pregnancy, identified using Spiegelberg's criteria and ultrasound, may mimic ovarian cysts and requires conservative surgery or oophorectomy depending on lesion size and stability. Across all types, early diagnosis and individualized management are critical to reduce maternal morbidity and mortality.

PRESENTER 5



Dr. Soundarya valli .P

Second year post graduate

Dept of obg

CORNUAL PREGNANCY HETEROTROPIC PREGNANCY

CESAREAN SCAR ECTOPIC PREGNANCY,

PREGNANCY OF UNKNOWN LOCATION

SUMMARY :

Cornual or rudimentary horn pregnancy is a rare form of ectopic pregnancy associated with a unicornuate uterus, where implantation occurs in the non-communicating rudimentary horn. It often presents late, carries high risk of rupture, and requires surgical excision. Heterotopic pregnancy is the coexistence of intrauterine and extrauterine gestations, more common with assisted reproductive techniques. Diagnosis is challenging as the intrauterine pregnancy may mask the ectopic component, and management aims to preserve the intrauterine pregnancy while treating the ectopic. Cesarean scar ectopic pregnancy (CSEP) occurs when the gestational sac implants into a previous cesarean scar. It may lead to uterine rupture or severe hemorrhage if untreated, with options including medical therapy (methotrexate), surgical excision, or interventional radiology. Pregnancy of unknown location (PUL) refers to a situation where pregnancy is confirmed biochemically but not visualized on ultrasound. Close follow-up with serial β-hCG and imaging helps distinguish between early intrauterine pregnancy, miscarriage, or ectopic.

THANK YOU