ED QUICK QUIZ

WHAT IS THE DIAGNOSIS?

BACKGROUND

A 24 year old woman presents to A&E with a 24 hour history of progressive right iliac fossa pain. It is constant and severe and there are no associated urinary, GI or PV symptoms. She has taken paracetamol and ibuprofen with no relief. There have been no similar previous episodes.

She is sexually active but does not think she could be pregnant as her boyfriend uses a condom. She has had a chlamydia infection in the past but otherwise has no medical history.

Examination

She is obviously in pain and there is tenderness in the right iliac fossa. There is no guarding and bowel sounds are present.

Observations

HR 88, BP 112/58, RR 18, SpO2 97% air, temperature 36.2

QUESTIONS

1. What is your differential diagnosis?
2. What investigations would you perform?

   She loses consciousness and collapses en route to the toilet. You reassess:

   HR 130 BP 84/46 RR 24 SpO2 98% Temp 37.8

   She looks pale, CRT is 3-4 seconds and there is now guarding in the abdomen.
3. What do you do now?

ANSWERS & DISCUSSION

1. Differential diagnosis

Ectopic pregnancy, appendicitis, ovarian torsion, UTI, PID and endometriosis are important differentials, but in child-bearing age women an ectopic should be ruled out first. Do not be fooled by the use of barrier contraception - although it significantly reduces her risk this method is not infallible and patients may not be as consistent in its use as they claim.

Risk factors for ectopic pregnancy include previous ectopic, salpingitis, tubal surgery, endometriosis, gamete intrafallopian transfer, IUCD and the POP.

Clinical features associated with ectopic pregnancy include iliac fossa pain, syncope and PV bleeding. Rupture causes sudden increase in pain, peritonism and shock. Shoulder tip pain indicates peritoneal irritation. There is usually a history of amenorrhoea for about 8 weeks.

Atypical presentations occur with isolated vomiting, presyncope, diarrhoea or pain on urination/defaecation.

2. Investigations

At presentation she is clinically stable, but if there is an ectopic pregnancy this could rupture any time. Obtain venous access with two large bore cannulae, send bloods including HCG and group and save and obtain a urine sample. Note that the pregnancy test kits work with a drop of blood - this is faster than waiting for lab or urine results.

As soon as you have determined the patient is pregnant get in touch with the O&G doctor on call who will be able to perform an ultrasound to determine whether the pregnancy is in the uterus or fallopian tube (or, in heterotopic pregnancy, in both). Note that if the pregnancy is less than 5 weeks a gestational sac may not be visualised on ultrasound.

3. Emergency Management

This lady has an ectopic pregnancy which has just ruptured. Move her to resus, obtain venous access and start fluid resuscitation. Cross match for 6 units but consider early use of O negative if haemodynamically unstable. Catheterise and measure urine output. FAST scanning may show free fluid but this should not delay resuscitation or referral to O&G.