

SUCCESS STORIES: RECURRENT TUBAL PREGNANCY**S Nagaraj¹ V. Nidhin² Mulla Ummesalma³**

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ABSTRACT

Tubal pregnancy is a clinical challenge to any physician concerned with the field of female infertility. Once tubal pregnancy occurs, the chances of tubal pregnancies to follow are higher. Literature identifies multiple aetiologies for the increased prevalence of tubal pregnancy in the current era. These include increased prevalence of chronic pelvic inflammatory disease, tubal plastic operations, ovulation induction and IUD use. Success stories in cases of repeated tubal pregnancies and failed ART procedures are not highly promising. Presenting here a case of repeated tubal pregnancies and failed ART procedures managed and succeeded by the ayurvedic protocol. A female patient aged 35 years with complaint of no issues since last six years of marriage and history of frequent tubal pregnancies came for consultation at SDM college of Ayurveda, Udupi one and half year ago. History revealed randomised treatment of AKT for over a period of 9 months at young age as well as reducing levels of anti-mullerian hormone. With time running away from her favour, treatment was designed keeping in mind for a uterine conception as well as sustenance of the labour. The following target was achieved by adapting Yuktivyapasaraya Chikitsa along the lines of Antarvidradhi/Gulma as well as Satwavajaya and Daivavyapasaraya Chikitsa.

Keywords – Tubal pregnancy, Mahakalyanaka Ghrita, AMH

INTRODUCTION:

Ectopic pregnancy also known as ectocyesis or tubal pregnancy is a complication of pregnancy in which the embryo attaches outside the uterus. Most ectopic pregnancies occur in the fallopian tube (90%) which is known as tubal pregnancies. There are a number of risk factors for ectopic pregnancies, but in as many as one third to one half no risk factors can be identified. The increasing prevalence of tubal pregnancies is due to chronic inflammatory

disease, tubal plastic operations, ovulation induction and IUD use. Early diagnosis and therapy has helped to reduce maternal deaths due to ectopic pregnancy. The incidence varies from 1 in 300 to 1 in 150 deliveries¹.

Very few clinical conditions exhibit features similar to that of tubal pregnancy. The clinical types are correlated with the morbid pathological changes in the tube subsequent to implantation and the amount of intraperitoneal bleeding. Clinically three distinct types

are described: acute, sub-acute and unruptured ectopic pregnancy².

Up to 10% women with ectopic pregnancy have no symptoms, and one third have no medical signs. In many cases symptoms have low specificity and can be similar to those of other genitourinary and gastrointestinal disorders, like appendicitis, salpingitis, rupture of corpus luteum cyst, miscarriage, ovarian torsion or urinary tract infection. Signs and symptoms of ectopic pregnancy include vaginal bleeding, abdominal pain, pelvic pain, tender cervix, an adnexal mass or adnexal tenderness. Tubal pregnancy is also increased in condition following ovulation induction and IVF-ET and GIFT procedures³.

A combination of quantitative B hCG values and sonography (trans vaginal USG) is used for the diagnosis of ectopic pregnancy⁴.

Getting pregnant after a tubal pregnancy can be difficult and there are risks. Once a tubal pregnancy occurs, there will always be damaged, scarred or blocked tubes. This will also damage the inner lining of the tube. In such conditions ectopics are often caused by scarred fallopian tubes which cause the early embryo to get stuck in the tube before it reaches the uterus.

Though there are no exact references within the Ayurvedic text books available for tubal pregnancies, we can adopt the Nidanas mentioned in diseases such as Jataharini, other yoni vyapats as well as conditions such as Antarvidradhi while approaching this case.

CASE STUDY

A female patient aged around 35 years, (house wife) first consulted SDM hospital, Udupi in the month of January

2014. She had no issues after marriage of six years. She is also a patient of recurrent headaches and is on regular medications for the same. One year after her marriage, she conceived and two months later it was identified to be tubal pregnancy. It was managed medically. 8 months later the patient conceived again and this time also it was a tubal pregnancy. The condition was managed by laproscopic salpingostomy.

The patient remained infertile over a period of two years and was on regular treatment but didn't conceive till 2013. She conceived once again in the month of January and turned out to be tubal pregnancy. In the month of March 2013 patient tried for IVF which failed. The reason as explained by their doctor was poor quality of egg. In the month of August the patient attempted another IVF attempt, but this time again the implantation occurred in the tubes and was treated with medical management. After three consecutive ectopic pregnancies and two failed IVF attempts, the patient consulted our OPD in the month of January 2014.

Detailed case history of the patient revealed a past history of amenorrhea, loss of appetite, loss of weight, pain abdomen over a period of 6 months during the age of 18 years. She had consulted a hospital nearby and had taken treatment for a period of 9 months for (?)Tuberculosis. She got complete relief from the presenting complaints and was said to be asymptomatic. There was no family history of infertility for the couple. She had a menstrual cycle of 2-3 days with regular 23 day cycle. There was normal menstruation and no episode of severe dysmenorrhea or associated com-

plaints. Detailed case history of the patient was taken and routine investigations as well as investigation to rule out other causes of salphingitis and PID such as TORCH and presence of Mycobacterium tuberculii were performed. The patient came to be negative in these tests. Rest of the vital parameters was found to be normal. Her husband was also investigated (semen analysis as well as detailed case taking) for any probable aetiological factor.

The patient was treated simultaneously for the complaint of tubal pregnancy as well as recurrent headache. Stress and frequent sinusitis were identified to be aetiologies of recurrent headache in this patient. Though an exact Nidana (cause) for the repeated tubal pregnancy was not identified, we considered the present condition in the terms of Antarvidradhi and yuktivyapasraya treatment was adopted accordingly.

TREATMENT PROTOCOL

The patient was assessed and treatment was charted on OPD basis. She was initially started on treatment of Gandarahastadi erandataila (SDM ayurved pharmacy) 5ml HS for 3 days followed by Sukumara Ghrita (SDM ayurved Pharmacy) (10ml OD) for one month. Further follow up was charted on sittings of 3 months. For the complaint of recurrent headache (infertility induced stress leading to migraine) Pathyadi Kashaya (SDM ayurved pharmacy) was started as 10ml HS for a period of 3 months. Sukumara Ghrita was continued at same dose. For the next 3 months, the dose of Sukumara Ghrita was increased to 15 ml at 6am in the morning. In the next sitting after 3 months, mahadanwantara gutika(Arya Vaidya Sala, Kottakal) was started as one tablet thrice daily. AMH

was tested during this time and revealed to be <1 which was lower than the normal. The medicine was reassessed and Mahakalyanaka Ghrita was introduced stopping Sukumara Ghrita. Cap Ovarian (BAN Labs) was also added as 1-0-1. The sittings were made more frequent from 3 months to 1 month. In the next sitting Chandraprabha DS (SDM ayurved Pharmacy) was started as 1-0-1. The other medications were continued as the same. This course was continued for a period of 1 month. In between the patient developed episode of amenorrhea for 45 days and Ultrasound scan revealed uterine pregnancy with single live foetus gestational age 6 weeks. Subchorionic blood collection was seen. Seedling fibroid in the anterior wall of the uterus was noted. The patient was advised to consult a Gynecologist near by who advised complete bed rest and introduced progesterone pill for complaint of spotting.

DISCUSSION

There were multiple factors in this case that made this an unusually challenging one. The progressing age of the patient, the repeated tubal pregnancies, failed ART techniques, decreasing value of AMH as well as the past history of tuberculosis indicated a risky prognosis. The decreasing level of AMH was also pointing towards ovarian changes which would reduce her chances of a normal conception with the progressing time. The past history of tuberculosis might have been the factors which lead to the reduced patency of tube leading to tubal pregnancy.

The option of Ghitapana in this scenario was selected on the basis of consideration of the involvement of Vata

and Pitta Dosha in this condition. Considering the tubal pregnancy as a form of Antarvidradhi⁵, drug was selected. Sukumara Ghrita⁶ finds its reference in Sahasrayoga and can be indicated in contexts of female infertility as well as lower abdominal conditions, inflammations as well as abscesses. With the introduction of Pathyadi Kashaya⁷ and frequent counseling, the incidence of Infertility induced stress leading to migraine headache were managed successfully.

Upon the identification of reducing level of AMH, the treatment was reassessed and changed to Mahakalyanaka Ghrita and Chandraprabha Gulika. This change was designed owing to the multiple aetiologies involved in the disease such as recurrent tubal pregnancies, past history of (?)tuberculosis, failed ART techniques as well as the possibility of involvement of Daiva or Graha were considered. Hence a Ghrita Yoga mentioned for Vandyathva as well as Sarvagraha Nivarana was selected. Ovarian Capsule indicated in the context of ovulation regulation was selected to correct the ovulation. The contents such as Asoka, Pushpadhava rasa, Garbhadharak Yog etc in the Ovarian Capsule played a major role in the correction of the ovulation in the given patient. Chandraprabha was also selected to Support the reproductive health of the patient.

The success in this case could be attributed to multiple aspects. The selection of drugs was done assessing the key factors relating to the Vyadhi, the Dosha- Dooshya Avastha as well as the Samprapti of the disease. The patient was also very supportive and optimistic of the treatment. Frequent follow up of Nitya Snehapana for over a

period of one year was undertaken by the patient rigorously.

The possible outcome of the snehapana and the ovarian capsule would have been that the patency of the tube was maintained with the snehapana as well the ovarian reserve was improved with the ovarian capsule promoting environment for a successful uterine pregnancy. With the correct choice of drugs, the qualitative improvement of the tubes as well as the quantitative and qualitative improvement of the ovaries was acquired. This made the kshetra ready for implantation and the correction of the Vata dushti in the Garbhashaya by the Ghritapana made the development of Garbha possible in the Garbhashaya.

CONCLUSION

Infertility remains one of the major concern in reproductive medicine. Among them tubal pregnancy is a very challenging one. This particular case had many factors impairing normal conception but the appropriate treatment and systematic management made this a success story. The increasing causes of infertility especially the increasing scenario of conditions like PCOD which can hamper the female reproductive system can be attributed to the changes in lifestyle, specifically in the diet and routine activities developed in the last few decades. Hence further studies should be focused towards the multiple aetiologies mentioned in literatures and their relevance in current scenario.

REFERENCES:

1. D.C. Dutta, Text Book of Obstetrics , edited by Hiralal Konar, 7th Ed, New central book agency (P) Ltd. Pp.688, Pn.178

2. D.C. Dutta, Text Book of Obstetrics , edited by Hiralal Konar, 7th Ed, New central book agency (P) Ltd. Pp.688, Pn.180
3. D.C. Dutta, Text Book of Obstetrics , edited by Hiralal Konar, 7th Ed, New central book agency (P) Ltd. Pp.688, Pn.178
4. D.C. Dutta, Text Book of Obstetrics , edited by Hiralal Konar, 7th Ed, New central book agency (P) Ltd. Pp.688, Pn.183
5. Vagbhatacharya, AstangaHridaya, Dr.Anna Moreshwara Kunte, ChoukambhaPublication 2000,Varanasi.Pp-956,Page No 507
6. Sahsrayogam, Sujanapriya vyakya, edited by K.V.Krishnan Vaidyan and S.gopala Pillai, vidyarambam Publishers, Pp544, Pn367
7. Sahsrayogam, Sujanapriya vyakya, edited by K.V.Krishnan Vaidyan and S.gopala Pillai, vidyarambam Publishers, Pp544,Pn28

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