Ectopic pregnancy presenting with obturator nerve pain

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Abstract
A 27 year old woman had a three day history of pain in the cutaneous distribution of the left obturator nerve before she developed the classical picture of ectopic pregnancy with lower abdominal pain and vaginal bleeding. A left tubal pregnancy was subsequently confirmed by laparoscopy. Referred pain along the obturator nerve has been reported in other pelvic conditions, but has not previously been reported as a manifestation of ectopic pregnancy. Ectopic pregnancy may present with a very wide range of signs and symptoms and should be excluded in females of child bearing age with unexplained symptoms including pain anywhere from the shoulder down to the knee. (J Accid Emerg Med 1998;15:192–193)

Keywords: ectopic pregnancy; obturator nerve; referred pain

Case report
A 27 year old woman presented to the accident and emergency (A&E) department with a two day history of pain on the inner aspect of the left thigh, which later radiated to the left groin. There was no history of trauma. She had stopped taking the contraceptive pill one month before and her last menstrual period had been eight weeks ago.
On examination her vital signs were normal. The abdomen was soft, with no masses or tenderness and no herniae. There was a small non-tender lymph node in the left groin. The vulva was normal with no external signs of inflammation or abscess (vaginal examination was not performed in A&E). Hip movements were normal and did not exacerbate the pain. Neurovascular examination of the lower limbs was normal. There was slight breast tenderness and pregnancy was confirmed by a urine test (Q Beta HCG Test, Quadracec). The patient was admitted to the surgical ward for observation and the following day developed some vaginal bleeding and was noted to have mild tenderness over the left iliac fossa. The pain in her thigh had disappeared. The patient was referred to a gynaecologist who found bleeding through the cervix during vaginal examination, with no tenderness and no palpable masses. Ultrasound examination showed no evidence of intrauterine pregnancy, but a suspicion of an adnexal mass adjacent to the left ovary. A laparoscopy was performed which revealed tubal pregnancy which was treated by a salpingotomy and suction irrigation. The patient made an uneventful recovery.

Discussion

The presentation of ectopic pregnancy may be acute, silent, or subacute. The acute presentation is associated with tubal rupture and massive intra-peritoneal haemorrhage causing acute abdominal pain and cardiovascular collapse. Silent ectopics are occasionally detected during routine ultrasound or antenatal clinic examination which may elicit localised tenderness and swelling in one fornix. In the subacute form the first feature is usually pain (95% of cases) and amenorrhoea followed by vaginal bleeding (75% of cases), but diagnosis of ectopic pregnancy is sometimes difficult on clinical grounds because of the varied presentation. The clinical triad of amenorrhoea, abnormal vaginal bleeding, and lower abdominal pain often raises the suspicion of the diagnosis. There are, however, instances where one or other feature of the triad may be absent. Sometimes ectopic pregnancy presents with an unusual clinical picture, for example lower gastrointestinal haemorrhage, simultaneous bilateral tubal pregnancy, acute tubal pregnancy with negative pregnancy test, or referred pain due to intra-peritoneal blood (pain in the shoulder or perineum secondary to irritation of diaphragm or pouch of Douglas, respectively), but referred pain in the distribution of the obturator nerve as a sign of ectopic pregnancy has not been described previously. The ovary and tube lie on the peritoneum of the side wall of the pelvis in the shallow ovarian fossa, in the angle between the internal and external iliac vessels, overlying the obturator nerve. The parietal peritoneum, against which the ovary lies, is supplied by the obturator nerve. A diseased ovary (and tube) may therefore cause referred pain along the cutaneous distribution of this nerve. Such pain has been recorded in many other pelvic conditions, for example endometriosis, retro-peritoneal haemorrhage, retro-peritoneal space occupying lesions, aneurysm of the hypogastric artery, and obturator hernia.

This case illustrates the need to consider ectopic pregnancy in females of reproductive age presenting with unexplained symptoms including pain anywhere from the shoulder down to the knee.

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