



Ectopic Pregnancy Remains a Problem

Moshe Hod*

Department of Obstetrics and Gynecology, University Cattolica, Rome, Italy

COMMENTARY

In Ectopic pregnancy, which affects 1%–2% of all pregnancies, is linked to a higher risk of abrupt bleeding and is still a primary cause of maternal death, despite a decrease in the last 25 years. This is especially true in the case of African-Americans. Tubal rupture typically occurs within 6–8 weeks of conception, emphasising the importance of clinicians in a variety of disciplines, including paediatrics, family medicine, and emergency care, as well as obstetricians and gynaecologists, being aware of this probable diagnosis. Damage to the fallopian tube mucosa is a significant cause of ectopic pregnancy, and it is known that the frequency of ectopic pregnancy is higher in populations at higher risk for both manifest and occult sexually Transmitted Infections (STIs). While STIs are a primary cause, the study points out that there is considerable evidence, both epidemiologic and experimental, that ectopic pregnancy is linked to other risk factors and can originate in otherwise normal fallopian tubes. They looked at lifestyle and reproductive variables that were linked to an increased risk of ectopic pregnancy in 22,356 women who signed part in the Nurses' Health Study II between 1990 and 2009. Nurses who were dependable historians of their reproductive history supplied a huge data set of 41,440 pregnancies, which were evaluated.

In their study, the rate of ectopic pregnancy was 1%, which was similar to the rate reported in prior studies. When compared to never-smokers, current smokers had 1.73 times (95 percent confidence interval [CI] 1.28–2.32 times) the risk of ectopic pregnancy. Former smokers had 1.22 times the risk, which was equivalent to that of never-smokers after 10 years. A new study indicated that drinking more than 10 grammes of alcohol each day increases the risk by 1.5 times when compared to never drinkers. Women who had in utero exposure to diethyl stilbestrol (DES), as well as current IUD use, past tubal ligation,

and a history of infertility, had an increased chance of tubal pregnancy. Women who started using oral contraceptives before the age of 16 were shown to have a higher chance of ectopic pregnancy, but this link was thought to be a sign of riskier sexual activities, which raised the risk of STIs. Despite the fact that many of these findings are not new, with the exception of the link to alcohol consumption, they confirm prior case-control studies with smaller sample sizes, which could have been prone to recollection or selection bias.

The authors speculate that cigarette smoking and alcohol use may have a role in ectopic pregnancyogenesis by changing the motility of normal fallopian tubes. Experiments on laboratory animals have previously been provided as evidence for this idea. E2 and P levels in the blood have also been found to be low in women who have had ectopic pregnancies. Do they represent the blastocyst's altered bioactivity of hCG or the creation of a faulty corpus luteum during ovulation? Could these low amounts of sex steroids play a function in modifying tubal transport of the fertilised egg, resulting in delayed embryo movement within the fallopian tube, because sex steroids have been found to play a role in oviductal motility? What about women who have no obvious risk factors but have an ectopic pregnancy? We previously showed the inaccuracy of a medical history by documenting evidence of a past pelvic infection through laparoscopy without the patient's knowledge. Antibodies to Chlamydia trachomatis have also been found in women who have had an ectopic pregnancy but have never had a STI, and evidence has been given suggesting antibodies to the C. trachomatis 70-kDa heat shock protein may play a role in tubal mucosal injury pathogenesis.

Alternatively, investigations conducted by Blaudau in rabbits with extensive fimbria in their oviducts, similar to those found in humans, support aetiology of ectopic pregnancy that is unrelated to damaged fallopian tubes. They showed

Received: 02- February -22

Manuscript No: IPGOOCR-22-12559

Editor assigned: 03- February -22

PreQC No: IPGOOCR-22-12559 (PQ)

Reviewed: 18- February -22

QC No: IPGOOCR-22-12559

Revised: 22- February -22

Manuscript No: IPGOOCR-22-12559 (R)

Published: 28- February -22

DOI: 10.21767/2471-8165.1000010

Corresponding author: Moshe Hod, Department of Obstetrics and Gynecology, University Cattolica, Rome, Italy; E-mail: hod.moshe@edu.it

Citation: Hod M (2022) Ectopic Pregnancy Remains a Problem. Gynecol Obstet Case Rep. Vol.8 No.2:10.

Copyright: © Hod M. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

that the cumulus oophorus, which surrounds the ovulated egg as it travels from the ovary to the tubal ostium, is critical. Cumulus-free eggs showed delayed transit into the oviduct after enzymatic removal of the cumulus. The highly negatively charged glycosaminoglycans in the cumulus interacted with the ciliated fimbria, assisting the egg's movement, they suggested. Ectopic pregnancy can develop in healthy fallopian tubes, and the lack of a previous STI does not rule out the possibility of a diagnosis. Knowledge of the risk factors linked to a higher likelihood of this diagnosis will not only lower the risk of rapid haemorrhage and death, but will also raise the likelihood of an earlier diagnosis, allowing for successful medical therapy without the risks and costs of surgery. Furthermore, if surgery is required, the fact that ectopic pregnancies can develop in normal fallopian tubes should provide justification for tubal preservation [1-5].

REFERENCES

1. Abbott L (2004) Ectopic pregnancy: symptoms, diagnosis and management. *Nurs Times* 100(6): 32-33.
2. Alalade AO, Smith FJ, Kendall CE, Odejinmi F (2017) Evidence-based management of non-tubal ectopic pregnancies. *J Obstetr Gynaecol* 37(8): 982-991.
3. Patrick JD (1982) Ectopic pregnancy- a brief review. *Ann Emerg Med* 11(10): 576-581.
4. Musa J, Daru PH, Mutahir JT, Ujah IA (2009) Ectopic pregnancy in Jos Northern Nigeria: prevalence and impact on subsequent fertility. *Nig J Med* 18(1): 35-38.
5. Shobeiri F, Tehranian N, Nazari M (2014) Trend of ectopic pregnancy and its main determinants in Hamadan province, Iran (2000-2010). *BMC Res Notes* 7(1): 1-5.