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CASE REPORT

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Twin Tubal Ectopic Pregnancy – A Case Report of a Rare Unilateral Fallopian Tube Twin Ectopic

Charles Lukanga Kimera[1]*, Frans Nghihevali Nghoshi[1], Jean C Hategekitekimana[2], Nsangamay Tshimanga[1], Frieda Silvanus[1], Beata Iita[1], Elsa Joaquim[1], Juventus Palapala[1], Teopolina Ndemuweda[1], Sofia Johannes[1], Renate Shinyemba[1], Kauna-pawa L Haipinge[1], Leefa MMM Shikongo[1], Regina Namupolo[1], Rovisa Peneyambeko Shikomba[1], Leena Nghixulu[1], Claudia Matutu[1], Nuule Heresmite[1] and Saara Iyambo-Hangula[1]

[1]Department of Obstetrics and Gynaecology, Onandjokwe Intermediate Hospital, Ministry of Health and Social Services, Namibia.

[2]National Reference Laboratory, National Institute of Pathology Limited, Windhoek, Namibia.

ABSTRACT

The occurrence of unilateral twin ectopic pregnancy is exceedingly rare and may be fatal as it poses a diagnostic challenge. Due to the rapid expansion in size caused by the two fetuses, it conspicuously leads to earlier tubal rupture as the fallopian tube does not naturally expand like the uterus does. Death results from catastrophic blood loss especially if the diagnosis is delayed or if the appropriate treatment is not provided in time. The use of transvaginal ultrasound combined with βhCG aids early diagnosis and has led to reduction in mortality resulting from ectopic pregnancy. We present a 24-year-old primigravida who presented to our hospital at 8 weeks of amenorrhea plus 1 day with symptoms and signs of a ruptured ectopic pregnancy. A transvaginal ultrasound revealed twin ectopic pregnancy in the right Fallopian tube which was confirmed at laparotomy. This case captured our interest because it is so rare and thought that sharing it with a wider community will contribute knowledge to the world of academia.

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Ectopic, Twin, Pregnancy, Unilateral, Ectopic pregnancy, Twin pregnancy, Transvaginal ultrasound.

Introduction

Ectopic pregnancy refers to a pregnancy in which the fertilized ovum (the zygote) implants outside the normal endometrial lining of the uterine cavity. The most common site for ectopic pregnancy (97%) is the Fallopian tube. Worldwide, ectopic pregnancy remains the leading cause of maternal mortality in the first trimester. About 5% of women present in hemorrhagic shock. Pallor, tachycardia and hypotension should alert the health provider to major abdominal bleeding, regardless of the intensity of abdominal pain. Abdominal distension accompanied with tenderness and rebound tenderness, shoulder pain from irritation of the diaphragm, and cervical excitation tenderness are additional important signs to be looked for. Vomiting and diarrhea may be the presenting symptoms of abdominal bleeding. Usually, women with ectopic have a period of amenorrhea, the length of which depends on the site of the ectopic.

Although concurrent tubal ectopic pregnancy and an intrauterine pregnancy have occasionally been seen, unilateral twin ectopic pregnancy is conspicuously rare thus necessitating sharing with a wider community including medical students and practitioners.

Case Summary

A 24-year-old primigravida at 8 weeks + 1 day gestation by LNMP, unbooked for antenatal care, was referred from a District Hospital with a 1-day history of sudden-onset of severe right lower abdominal pain (8/10), radiating to the right shoulder. The pain was persistent, progressively worsening, aggravated by movement and coughing, and was associated with brownish per vaginal discharge, dizziness, nausea, and headache. Her gynecological history was significant for regular 28-day menstrual cycles, having attained her menarche at the age of 14 years. She had no history of pelvic inflammatory disease or dyspareunia. She had previously used injectable contraception and condoms. Socially, she had coitarche at the age of 14 years and so far, had had 4 life-time sexual partners.

On examination, she was alert, afebrile, BP – 117/77 mmHg, Pulse – 122bpm (tachycardia), moderately pale (hemoglobin – 8.5g/dl). Pregnancy test was positive. The abdomen was tender, most marked in the right iliac fossa, with rebound tenderness and guarding. Vaginal and bimanual examination revealed a closed cervical Os, cervical excitation tenderness and the uterus was slightly enlarged.

Transvaginal ultrasound demonstrated a bulky uterus with a decidualized endometrium but no intrauterine gestational sac, a right adnexal mass with two gestation sacs, and copious free fluid in the pouch of Douglas, figure 1. A diagnosis of ruptured twin ectopic pregnancy was made and the plan was to perform an emergency laparotomy plus salpingectomy.

The patient was prepared for theatre and emergency laparotomy was performed with intra-operative finding of a partially ruptured right ampullary ectopic pregnancy with two fetuses each in its amniotic sac, Figure 2, and hemoperitoneum

Contact: Charles Lukanga Kimera, Department of Obstetrics and Gynaecology, Onandjokwe Intermediate Hospital, Ministry of Health, Social Services, Namibia.

of 1000ml. Salpingectomy was performed and the specimen was sent for histology. The patient was treated with antibiotics and analgesia and 2 units of red blood concentrate (RCCs) were transfused. By the 3rd post-operative day, she had recovered well and was discharged from hospital. She was reviewed 4 weeks later and she was in good condition.

Histological report confirmed a ruptured Fallopian tube demonstrating chorionic villi and extravillous trophoblastic tissue within the tubal lumen and associated hemorrhage with no evidence of trophoblastic disease, Figure 3.

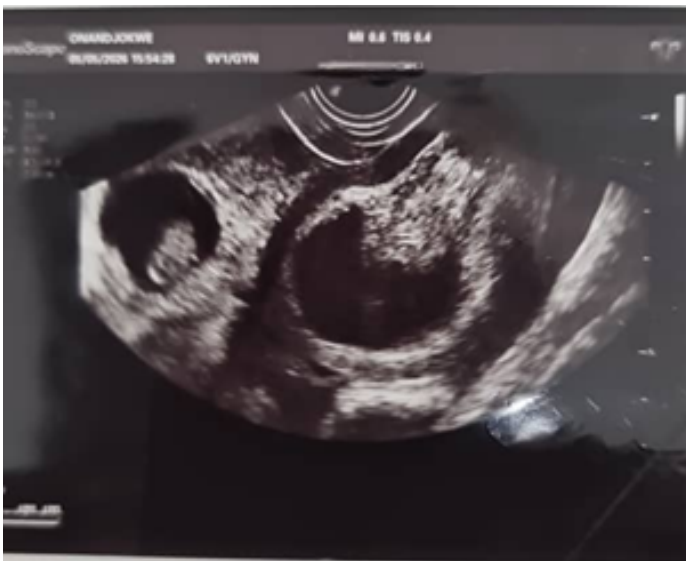

Figure 1: Transvaginal ultrasound showing two fetuses each in its amniotic sac.

Figure 2: Results of the laparotomy - two fetuses from the right Fallopian tube and the placenta.

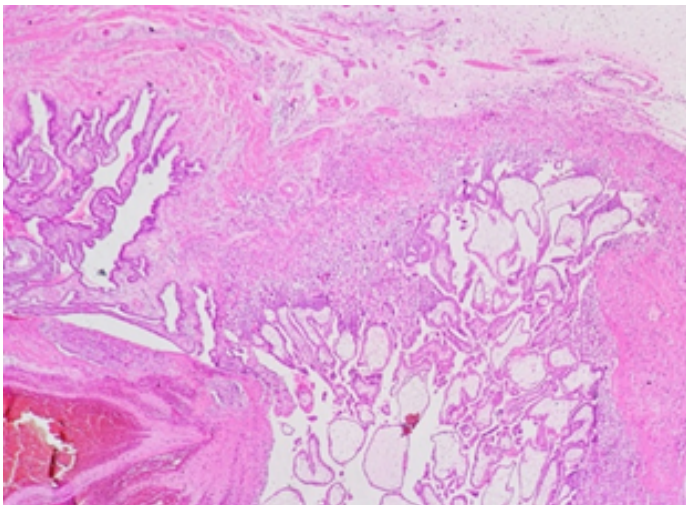

Figure 3: Histological section of the ruptured fallopian tube demonstrating chorionic villi and extravillous trophoblastic tissue within the tubal lumen, associated with hemorrhage. Residual fallopian tube mucosa is present in the upper left corner (H&E stain).

Discussion

Ectopic pregnancy refers to a pregnancy in which the fertilized ovum (the zygote) implants outside the normal endometrial lining of the uterine cavity, i.e. the fallopian tubes, cervix, ovary, cornual region of the uterus, and abdominal cavity. It accounts for about 2% of all pregnancies. The commonest site for ectopic pregnancy is the Fallopian tube (97%) and most (80%) of these Fallopian tube ectopic pregnancies occur in the ampullary part of the tube. Since the Fallopian tube cannot expand like the uterus, as the gestation enlarges it eventually ruptures as it cannot accommodate the enlarging fetus and the placenta as was the case for our patient. This can lead to massive hemorrhage, infertility, or death.

Risk factors

The risk factors for ectopic pregnancy include Previous ectopic pregnancy, previous tubal surgery, documented tubal pathology, previous genital infections (pelvic inflammatory disease [PID], infertility & infertility treatment, lifetime number of sexual partners > 1 and smoking (reduced tubal motility) [1]. However, we think that the above factors withstanding, what causes twin ectopic pregnancy is similar to what is responsible for intrauterine twin pregnancy i.e. multiple ovulations resulting in two ova becoming fertilized by 2 different sperms; and cleavage of a fertilized single ovum. The only risk factor for ectopic pregnancy found in our index case was 4 life time sexual partners.

Prevalence of twin ectopic pregnancy

Although concurrent tubal ectopic pregnancy and an intrauterine pregnancy (heterotopic pregnancy) are occasionally seen, unilateral twin ectopic pregnancy is conspicuously rare, occurring in around 1 in 125,000 spontaneous pregnancies [2,3]. In our hospital twin ectopic pregnancy has never been reported since its inception in 1911 till the current case.

Clinical presentation and diagnosis for ectopic pregnancy

Ectopic pregnancy usually presents with a period of amenorrhea followed by abdominal pain that usually starts sharply in either

of the iliac fossae, right or left, before becoming generalized. Shoulder pain, nausea and vomiting, abdominal distention and dizziness depending on the amount of the invisible blood loss may accompany the above symptoms. Vaginal bleeding, usually without blood clots, may be present in about 60-80% of the cases [4,5]. In our case the patient presented with 8 weeks and 1 day of amenorrhea, a positive pregnancy test, a 1-day history of sudden-onset severe right lower abdominal pain radiating to the right shoulder.

Physical examination usually reveals a patient in pain, pallor of the mucous membranes, a low blood pressure and a high pulse (tachycardia). Abdominal examination reveals a distended abdomen with tenderness and rebound tenderness and on vaginal examination there is cervical excitation tenderness and the posterior vaginal fornix may be bulging into the vagina if there is significant hemoperitoneum. In our case the patient presented with a relatively normal BP of 117/77 mmHg, Pulse of 122bpm, and she was moderately pale (hemoglobin – 8.5g/dl). The abdomen was tender, most marked in the right iliac fossa, with rebound tenderness and guarding. Vaginal and bimanual examination revealed a closed cervical Os, cervical excitation tenderness and the uterus was only slightly enlarged.

The diagnosis of twin ectopic pregnancy is made based on the above clinical picture plus ultrasonographic examination findings. The American college of obstetricians and gynecologists (ACOG) and the Royal college of obstetricians and gynecologist (RCOG) recommend the use of transvaginal ultrasound to diagnose ectopic pregnancy [6,7]. A tubal pregnancy should be suspected if ultrasonography reveals gestational tissue in the adnexal area without any evidence of an intrauterine pregnancy. If a yolk sac or embryo is seen in the ectopic gestational tissue, the diagnosis of ectopic pregnancy is definitively confirmed. If a small fluid collection is seen in the uterine cavity, this may represent a pseudogestational sack. An echogenic fluid collection in Douglas' pouch is likely to be a hemorrhage, such as is seen in one-third to one-half of all cases of tubal pregnancy [8,9].

In our case we performed a transvaginal ultrasound which revealed a bulky uterus with a decidual cast but no intrauterine gestational sac, a right adnexal mass with two gestation sacs each with and embryo, and copious free fluid in the pouch of Douglas, Figure 1.

Management

The survival of a patient with ectopic pregnancy depends on making a correct diagnosis and providing prompt treatment. Death usually results from failure to make a correct diagnosis or delaying the recommended treatment. The management of twin ectopic pregnancy is similar to that of non-twin ectopic pregnancy provided it meets the criterion the managing clinician has chosen to provide. The management of a ruptured ectopic pregnancy is either salpingostomy or salpingectomy which may be approached either laparoscopically or by laparotomy depending on the patient's hemodynamic state. Because our patient had tachycardia, a low Hb and substantial amount of peritoneal fluid (hemoperitoneum), we chose to perform laparotomy. The findings at laparotomy confirmed the twin pregnancy seen on transvaginal sonar, Figure 2.

Conclusion

Ectopic pregnancy is a condition requiring early recognition, with a high index of clinical suspicion and a precise clinical diagnosis in any woman of child bearing age presenting with a period of amenorrhea, abdominal pain, or bleeding even in the absence of risk factors. Unilateral tubal twin ectopic pregnancy is an exceptionally rare and potentially life-threatening condition; its preoperative diagnosis via high-resolution transvaginal ultrasonography permits prompt clinical intervention, ultimately reducing maternal morbidity and mortality.

In our health facility, unilateral tubal twin ectopic pregnancy is unprecedented and worthy of clinical curiosity. Continued reporting of similar cases will contribute knowledge to unusual cases, to expand understanding as well as evidence-based knowledge from real clinical cases, and to develop recommendations for diagnosis and management.

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