A 38-year-old, P³⁺², woman with history of bilateral salpingectomy. When seen in the Accident and Emergency Department, the patient’s vital signs were normal and physical examination revealed slight tenderness in lower abdomen with no guarding. Pelvic examination revealed a slightly tender uterus enlarged to 6 weeks size. There was no adnexal tenderness and no pain on vaginal movement. Serum β-human chorionic gonadotropin (hCG) was 3,578 iu/L and transvaginal ultrasound scan showed a collapsed intrauterine gestational sac of 27 mm with a possible yolk sac with no definite contents. A repeat serum β-hCG after 48 hours dropped to 1,414 iu/L. It was assumed that this was a noncontinuing intrauterine pregnancy. The same day, she had significant vaginal bleeding, and it was thought that she had miscarried. Emergency ultrasound facilities were not available to confirm this. At her request, evacuation of uterus was carried out, but only scanty material was obtained. The patient was quite traumatized by the overall experience and wanted to go home as soon as possible. She was therefore discharged home the same day and advised to contact the unit directly if she had any pain or bleeding, so that she could be assessed and serum β-hCG or ultrasound scan repeated as deemed necessary. The histology of the uterine curettings, which was available a week later, showed hypersecretory endometrium with no chorionic villi or fetal parts.
In view of the histology, the patient was seen again in the clinic. She was clinically well, with no abdominal pain or abnormal vaginal bleeding. She was absolutely certain that she could not go through a similar experience in the future. Although the patient was informed that the likelihood of recurrence was very small, it was considered logical to offer her alternative contraception. She opted for the Mirena Levonorgestrel intrauterine system (Schering Health, Burgess Hill, West Sussex, UK).

**DISCUSSION**

Although tubal sterilization is very effective in preventing pregnancy, there is a cumulative failure rate of 18.5 per 1,000 for all methods combined (1). For individuals in whom sterilization fails, it has been suggested that bilateral salpingectomy is the correct treatment (2). This has been the traditional practice and indeed must be very effective because, based on a MEDLINE search in the English-language literature, there appears to be no reported cases of spontaneous pregnancy, intrauterine or ectopic, following bilateral salpingectomy. We believe this to be the first reported case.

In the preceding case, the history, examination findings, and ultrasound scan were highly suggestive of an intrauterine pregnancy. The presence of chorionic villi in uterine curettage sample is conventionally held as definite evidence of an intrauterine pregnancy. In this case, histology did not reveal chorionic villi, leaving the ongoing doubt as to whether this was an intrauterine or ectopic pregnancy. It may be that the patient had completely miscarried before she had the evacuation of uterus. Moreover, it is known that in complete miscarriages, the uterine curettings may sometimes contain only endometrial fragments and histologic examination may not reveal chorionic villi (3). Similarly, chorionic villi have been occasionally found in uterine curettings of patients proven to have ectopic pregnancy (4). In such cases, it has been suggested that other signs of intrauterine implantation, such as an intermediate trophoblast, hyalinized vessels, and a fibrinoid matrix should be looked for. An intermediate trophoblast, however, is difficult to identify using conventional staining (4,5).

The possible explanation of a pregnancy in this patient is only from a patent cornual end. Fertilization may have occurred either inside the uterus or inside peritoneal cavity. One of the ways of confirming a patent cornual end would be by hysterosalpingography. We did not feel this was justified. Moreover, a fistulous tract may be so small that it may not be demonstrable on a hysterosalpingography (5).

**REFERENCES**