Pak Armed Forces Med J 2006; 56(1): 87-88

HETEROTOPIC PREGNANCY – A RARE SPONTANEOUS CASE

Nighat Sultana

Combined Military Hospital Multan

INTRODUCTION

Heterotopic pregnancy combined intra-uterine and an extra-uterine pregnancy, though rare is increasing in incidence. The following case of heterotopic pregnancy in a woman without known risk factors is presented to emphasize some of the problems and consideration involved in making this diagnosis difficult. Tubes are involved in 85% of cases [1]. Rarely, the ectopic implants in the cornual end of the uterus, pouch of Douglas and abdominal cavity. It is extremely difficult to diagnose and 50% cases can be identified only after tubal rupture. The prognosis for extra uterine fetus is very poor, having an estimated 90-95% mortality rate, while 35% for intrauterine.

CASE REPORT

An 18-years old primigravida, married for the last three months presented at 7 weeks gestational age with complaints of sudden onset of severe pain in lower abdomen and vaginal spotting for the last six hours. This was followed by nausea, vomiting and fainting attacks. Her menstrual cycle was regular. There was no history of pelvic surgery, pelvic inflammatory disease or intake of fertility drugs. This was a planned spontaneous conception. Her pregnancy test was positive, but there was no ultrasonic evidence available. On examination she was extremely pale and sweating. The blood pressure was 70/40 mmHg, and pulse 120/min. The abdomen was tense and revealed marked tenderness allover. On examination cervical os was closed with slight brownish vaginal discharge. There was fullness in all fornices and uterus size could not be assessed due to marked tenderness. She was immediately resuscitated with intravenous fluids.

Ultrasound done by sonologist revealed ruptured ectopic pregnancy. Her hemoglobin was 5 grams%. On emergency laparotomy, there was 3 liters of fresh and clotted blood in the peritoneal cavity .Both the tubes were intact but right was slightly swollen and bleeding, it seems like tubal abortion. Right salpingectomy was done. Specimen sent for pathologic examination. Both ovaries were normal looking and uterus was bulky. Haemostasis was secured and abdomen was closed. The patient had an unremarkable postoperative recovery. Histopathology confirmed the presence of placental villi and trophoblastic cells in fallopian tube.

About three weeks postoperatively she presented with persistent nausea and vomiting, on thorough examination ultrasound revealed normal intrauterine gestation of 10 weeks consistent with her LMP.

She was followed up regularly for fetal growth, and any other complications. She went into spontaneous labour at term and delivered a live normal male baby of 2.8 kilograms by vaginal route.

DISCUSSION

Heterotopic pregnancy is a rare complication of pregnancy especially in the absence of predisposing factors. Recently incidence has increased upto 1 in 5000-10,000 general population [2,3], is even much higher in women undergoing ovulation induction (3%) [4,5].. Another reason suggested for increased incidence is that ectopic pregnancy

Correspondence: Maj Nighat Sultana, Department of Obstetrics & Gynaecology, Combined Military Hospital Quetta.

have increased overall which may be attributed to the risk factors e.g. PID, pelvic surgery, use of IUCD etc.

It is known to present with variety of symptoms and signs, often leading to a delay in establishing the correct diagnosis. Early diagnosis is only possible if high degree of vigilance is maintained in all women at risk, although cases have been reported without any risk factor. The common tools for diagnosis of ectopic gestation are beta HCG levels, progesterone levels, and ultrasound to document an empty uterus. On the other hand diagnostic testing in a patient with heterotopic pregnancy will demonstrate the presence of viable intrauterine fetus on USG, raised beta HCG levels, progesterone levels within normal range. Once an intrauterine pregnancy is identified adnexae should be carefully examined, even then an adnexal mass is not found 15-35% times in ectopic pregnancy [6]. Therefore follow up USG should be performed 2 weeks following initial USG. However 50% heterotopic pregnancies are missed on USG.

In our patient, there was no history of any of the above- mentioned risk factors .She presented as a typical case of ectopic pregnancy and her intrauterine pregnancy was missed at initial presentation, which could be due to massive haemorrhage.

Surgical removal of the ectopic gestation by salpingectomy or salpingostomy is the treatment of choice. Expectant management has been successfully applied in selected cases. Successful salpingocentesis (with methotrexate and potassium chloride) has also been reported. Management should be according to the individual case. In our case patient was in shock due to intraperitoneal hemorrhage, so laparotomy had to be performed.

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