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HETEROTOPIC PREGNANCY- A RARE CASE REPORT

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Abstract : A heterotopic pregnancy is a rare complication of pregnancy in which both extra Uterine (ectopic pregnancy) and intra uterine pregnancy occur simultaneously. It may also be referred to as a combined ectopic pregnancy, multiple sited pregnancy or coincident pregnancy. The estimated incidence for a naturally conceived pregnancy is 130000. The incidence among patients with assisted reproduction is higher and is thought to be around 1-3100. Due to this assisted reproduction, the overall incidence has increased over the years. We report a case of heterotopic pregnancy in a 25 year old woman presented with hemoperitoneum from ruptured tubal pregnancy with failed intra uterine gestation at 9 weeks of amenorrhoea, diagnosed on ultrasound examination and treated by emergency laparotomy.

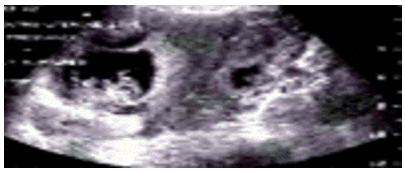
Keyword : Assisted reproduction, heterotopic, extra uterine, adnexal mass

INTRODUCTION:

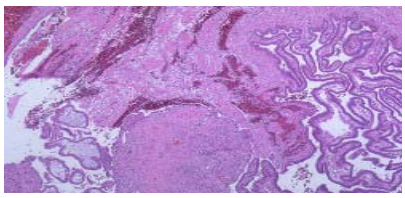
Heterotopic pregnancy is the existence of two or more simultaneous pregnancies with separate implantation sites, one of which is ectopic. Estimated incidence is 1 in 30000, but appears to be higher in those treated for infertility. Similar to ectopic pregnancy, most cases of heterotopic pregnancy occur in the fallopian tube. Other commonly affected sites include the cervix and ovary. The risk factors for heterotopic pregnancy include pelvic inflammatory diseases, reconstructive tubal surgery, previous ectopic pregnancy and assisted reproductive technologies.

CASE SUMMARY:

A 25 year old G2A1 , an unbooked case with no previous antenatal visits has come with 9 weeks of amenorrhoea with complaints of left sided lower abdominal pain and bleeding per vagina for past 4 hours. Her past obstetric history was a self induced medical termination of pregnancy at 8 weeks of amenorrhoea ,2 years back. Urine pregnant test was positive. On examination patient was pale, blood pressure 90/60 mmHg, pulse rate 102/min, per abdomen finding – abdomen distended, tenderness present in hypogastrium, per vaginal examination- cervix midposition, uterus enlarged to 10 weeks size, cervical motion tenderness present, left forniceal fullness present, blood on examining finger present. Culdocentesis done and found to be positive. Laboratorical investigations showed a haemoglobin of 8.3 g%. Transabdominal ultrasound revealed a failed intrauterine gestation of 9 weeks, moderate amount of free fluid in the peritoneal cavity and a complex left adnexal mass. Transvaginal ultrasound confirmed the findings. Provisional diagnosis of a heterotopic pregnancy with ruptured left ectopic gestation was suggested in view of clinical and ultrasound findings. Emergency laparotomy done and per operative findings: hemoperitoneum of 1 litre, ruptured left side tubal pregnancy, uterus enlarged to 10 weeks, both ovaries and right tube normal. Left salphingectomy done followed by suction evacuation for failed intrauterine pregnancy. 2 units of whole blood transfused intraoperatively. Post operative period uneventful and patient recovered well. Histopathological examination revealed the presence of chorionic villi in the specimens obtained from the tubal and intrauterine site.



Ultra-sound image of intra uterine pregnancy and left complex adnexal mass



Histopathology showing chorionic villi and tubal epithelium

DISCUSSION:

Heterotopic pregnancy was first described by Dueverney in 19081. Heterotopic pregnancies are becoming more common following assisted conception techniques for subfertility, probably due to the combined effects of hyperstimulation and the

subsequent , simultaneous transfer of several embryos into the uterus with retrograde flow into the fallopian tubes2,3. Indeed , any factor predisposing a patient to an increased risk of ectopic pregnancy may contribute to heterotopic pregnancy, however spontaneous heterotopic pregnancies are quite rare4. The majority of heterotopic pregnancy cases are diagnosed late. Often abdominal and pelvic ultrasonogram fails to show the ectopic pregnancy because of the awareness of an existing intrauterine pregnancy4,5 but demonstration of an intrauterine pregnancy is no longer a reliable indicator for excluding an ectopic pregnancy. The detection rate of heterotopic pregnancy by transvaginal ultrasonogram varies from 41-84%5. Sometimes the presence of a haemorrhagic corpus luteum can confuse and delay the diagnosis of heterotopic pregnancy6,7.

The management of heterotopic pregnancy remains controversial. Surgical treatment has been the traditional mainstay but involves surgical and anaesthetic risk. Studies suggest that laparoscopic management is preferred over laparotomy in patients with a suspected heterotopic pregnancy because of minimal manipulation of uterus8,9. A non surgical approach can be used safely and effectively to manage patients who are clinically stable and where a heterotopic pregnancy is recognised relatively early in gestation. The non surgical management includes potassium chloride injection into the tubal pregnancy10. In our case if heterotopic pregnancy has been diagnosed early, then it might have been possible to complete the surgery with the laparoscope, but because of hemodynamic instability in our case emergency laparotomy was arranged.

CONCLUSION:

We can conclude that heterotopic pregnancy must always be considered in patients presenting with abdominopelvic pain in face of a documented intra uterine pregnancy, because the presence of an intra uterine pregnancy can no longer be considered reassuring and a heterotopic pregnancy has to be ruled out. Thus, we recommend that all patients shown on ultrasonogram to have an intra uterine pregnancy should be given a comprehensive pelvic ultrasound so that the possibility of simultaneous heterotopic pregnancy may be excluded. We also emphasize the need for prompt and immediate action at the first sign which indicates a heterotopic pregnancy, to avoid missing this potentially life threatening condition.

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