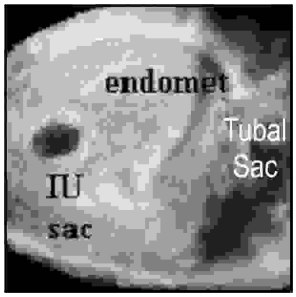
CASE REPORT PROF-1035

# HETEROTOPIC PREGNANCY

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**ABSTRACT...** A rare case of simultaneous tubal pregnancy and intrauterine pregnancy is discussed. Patient had an atypical presentation of abdominal pain and a abnormal uterine bleeding but no period of amenorrhea. On clinical examination there was suspicion of ectopic gestation but ultrasonography revealed early intrauterine pregnancy along with luteal cyst. Because of increase severity of pain she was reviewed again. Repeat sonography findings were consistent with heterotopic which was confirmed by laparotomy and histopathology.

**Key Words:** Combined Intrauterine and Tubal Pregnancy, Rupture, Intraperitoneal Hemorrhage, Ultrasonography, Laparotomy.

## CASE REPORT

A 30 years old women para 2 with one abortion, was initially seen on 8-10-98 history of Colicky pain of variable intensity in right half of lower abdomen for one and half months along with irregular vaginal bleeding for one month. She denied any history of amenorrhea and symptoms of early pregnancy. Her last normal menstrual period was on 15-9-98. She did not have any urinary bowel complaints. Previously patients had two term vaginal deliveries at home and one abortion at 12 weeks amenorrhea followed by D&C. Her blood pressure was 110/70 mm of Hg. Pulse 98/minute, temperature 98°F. Clinically she was not anaemic. On abdominal examination there was tenderness on deep palpation in right lower abdomen. Pelvic examination revealed closed cervix with 6 weeks size anteverted uterus along with an ill defined and tender mas in right adnexa.

Laboratory investigations revealed Hb 11.2 gram/dl detected on urine examination patients was found have a viable intrauterine pregnancy of 6 right luteal ovary. Patient was treated as case of threatened abortion but her Colicky pain increased in intensity along with persistence of mild episode of vaginal bleeding although she remained vitally stable. Repeat ultrasound on 11-11-98 confirmed the diagnosis of heterotopic pregnancy. Findings were right sided tubal pregnancy along with 8 weeks viable intrauterine pregnancy. There was blood collection in cul de sac. Repeat Hb was 10.2 grams/dl. The patient under general anaesthesia. There was. There was hemo-peritoneum. About 300-400 ml of blood along with clots removed. Omentum was adherent over right adnexa where as separated by blunt dissection and right sided tubal pregnancy was identified. Splingectomy was carried out because of

apparently damaged tube. Both ovaries and left tube were normal. Uterus was soft and of 8 weeks size. Histological examination confirmed the diagnosis. The postoperative recovery was uneventful. Before discharge her pelvic ultrasound was repeated which revealed viable intrauterine pregnancy having CRL of 3.5 cm.

## DISCUSSION

Heterotopic pregnancy is a rarity because of which diagnosis is usually missed at initial visit. Although all the factors leading of ectopic gestation can be blamed but two major contributory factors are:

- Sequele of PID and theand the relationship between PID, tubal obstruction and ectopic pregnancy is well documented Incidence of tubal blocked is 13% after episode of PID 35% after two episodes and 79% after three.

- Infertility treatment in vitro fertilization and embryo transfer (IVF/ET).

In a population in which PID (Pelvic inflammatory disease) was three times high the reported world incidence, the incidence of combined gestation was proportionally increased[4]. This patients had possibility of having PID as the had home deliveries by TBA'S (traditional birth attendants) and had an abortion followed by D&C).

Patient was initially diagnosed and treated as a case of threatened abortion on the basis of sonographic findings in which diagnosis was missed due to technical error. Her ultrasound was repeated which confirmed the diagnosis of heterotopic pregnancy. In suspicious cases laparoscopy should precede to laparotomy but if diagnosis is obvious then promt surgical intervention is a better approach. Salpingectomy was carried out because of the apparently damage tube due to adhesions. Furthermore, other tubes were normal so conservative surgery was not required in the involved tube.

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