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Case Report

Heterotopic Pregnancy: A Diagnosis We Rarely Suspect

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Abstract: Heterotopic gestation is uncommon in spontaneous conceptions; however the incidence is rising due to assisted reproductive techniques. A high index of suspicion can help in timely diagnosis and appropriate intervention. We report a case of heterotopic pregnancy in a 36-year-old woman who presented as threatened abortion with an adenexal mass.
Keywords: Adnexal mass, heterotopic ectopic, haemoperitoneum

INTRODUCTION:

Incidence of heterotopic pregnancy, defined as the coexistence of intrauterine and extrauterine gestation is very low in natural conceptions [1]. The frequency originally estimated to be 1/8000 and 1/30,000 is increasing due to assisted reproductive techniques [2].

CASE REPORT:

A 36 yr old third gravid with previous two vaginal deliveries, presented with acute pain abdomen since four hours, bleeding per vaginum since 4-5 days with two months amenorrhoea. On examination, pallor was present; pulse was 90 beats/minute, BP 110/70 mm Hg. On per abdomen examination, tenderness was present in lower abdomen. Per speculum examination revealed dark altered blood coming through os which was closed, cervix was deviated to right side. On per vaginal examination, uterus was soft, about 6 weeks size, anteverted, anteflexed, mobile, deviated to the right side. In left adenexa, a mass was felt, 6 cms size, and tender, separated from uterus. Right fornix was free and non tender.

Ultrasound showed intrauterine gestational sac of 7 weeks with sub-chorionic haemorrhage and 78x71 mm heterogeneous area noted in left adenexa with central anechoic area and vascularity suggestive of broad ligament fibroid with cystic changes and was advised to get MRI pelvis which showed soft tissue mass 90x72x81 mm in left adenexa with areas of haemorrhage suggestive of ectopic pregnancy. Left ovary was not seen separated from the mass. Uterine cavity was filled with blood products suggestive of decidual reaction with haemorrhage (Pseudo gestational sac). (Fig.1)

Laparotomy was done after informed consent. On opening, abdominal cavity was filled with around 200 cc dark coloured clots, adherent to the omentum and bowel. Uterus was 8 week size, right tube and ovary were normal. Left ovary was cystic, left tube was oedematous, covered with clots and a mass of 6 x 5 cm at its lateral half.(Fig.2)

Left salphingo opherectomy and right tubal ligation done. Abdomen closed back after irrigation. Manual vacuum aspiration of uterine cavity was done. Products obtained were saved and sent for histopathological examination. Report showed hyalinized products of conception in left tube and also products of conception in uterine curettage confirming heterotopic pregnancy. Two units of blood was transfused preoperatively and intraoperatively.

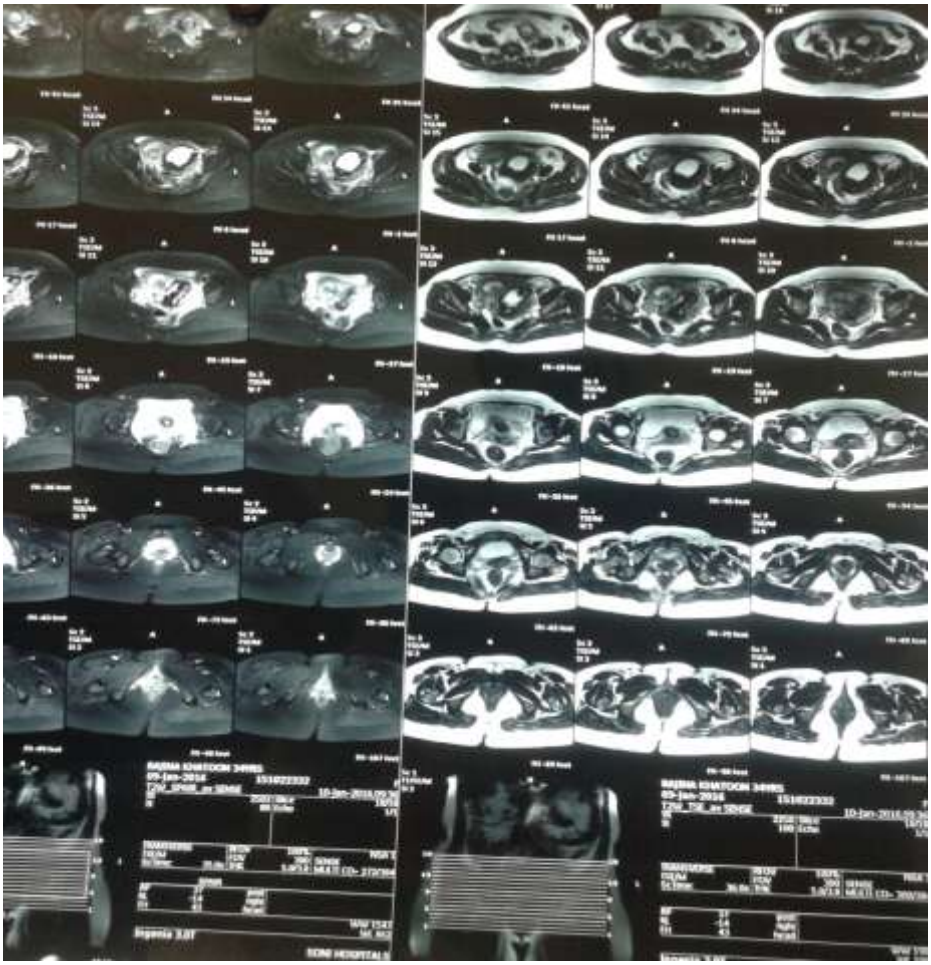

Fig. 1: MRI Pelvis Showing Gravid Uterus with Sub-Chorionic Haemorrhage, Left Adenexal Mass With Anechoic Area And Vascularity

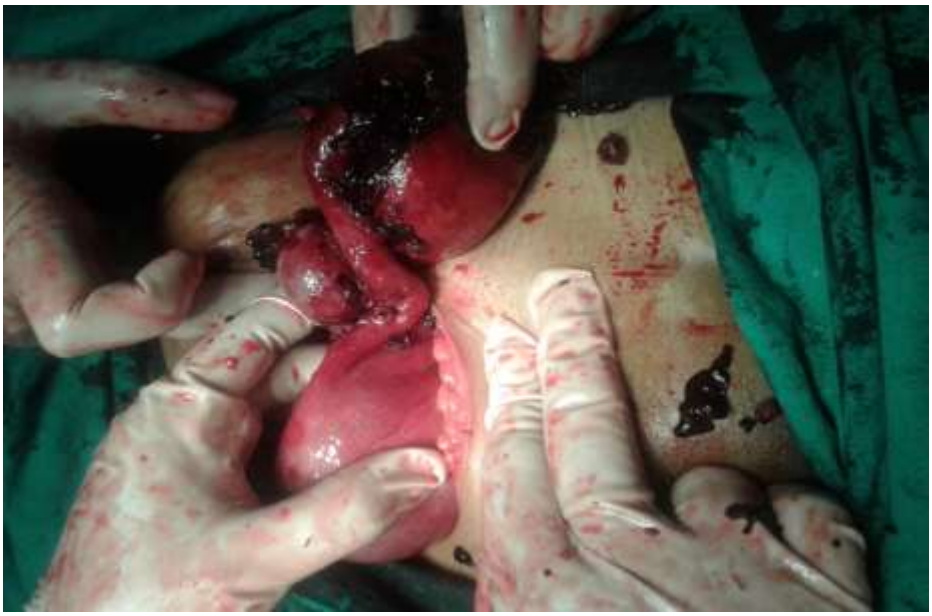

Fig. 2: Gravid Uterus with Left Ectopic Pregnancy

DISCUSSION:

It is a life threatening condition and early diagnosis is often difficult. A high index of suspicion is needed in women with risk factors for an ectopic pregnancy and in low risk women who have free fluid with or without an adnexal mass with an intrauterine gestation and acute abdomen [3]. A high index of suspicion should be raised in cases of acute pelvic pain

in the face of documented intra uterine pregnancy and can help in timely diagnosis and appropriate intervention. Intrauterine gestation with hemorrhagica corpus luteum can simulate heterotopic gestation both clinically and on ultrasound [4]. Bicornuate uterus with gestation in both cavities may also simulate a heterotopic pregnancy [5].

Serial β-HCG assays are made unreliable as subnormal hormone production by an ectopic pregnancy may be masked by the higher placental production from the intrauterine pregnancy [4]. High resolution transvaginal ultrasound with color doppler is helpful. Assessment of the whole pelvis, even in the presence of intrauterine pregnancy is an important aid in the diagnosis of heterotopic pregnancy. The trophoblastic tissue in the adnexa in a case of heterotopic pregnancy shows increased flow with significantly reduced resistance index [6].

Culdocentesis is an important aid in diagnosis when hemoperitoneum is presented as echogenic cul de sac fluid collection is more important than anechoic fluid because it indicates the presence of peritoneal hemorrhage. Variable outcome have been reported, live baby being born [7-9] or the intrauterine pregnancy resulting in a missed abortion [10]. Laparotomy for concurrent ectopic pregnancy does not appear to disrupt the intrauterine gestation when the gestational sac on ultrasonography is consistent with dates. The uterus should be only minimally and carefully handled in order to avoid disturbing the pregnancy. Laparotomy may be the preferable surgical modality in cases with serious intra-abdominal bleeding or in patients with hemorrhagic shock [10]. Laparoscopic surgery might be an appropriate method to manage some carefully selected patients with heterotopic ectopic pregnancy [3, 11].

CONCLUSION:

Heterotopic pregnancy should be considered in differential diagnosis of pregnancy with an acute abdomen. Detection of an intra-uterine pregnancy does not exclude the existence of an accompanying ectopic pregnancy.

REFERENCES:

1. Shetty SK, Shetty AK; A case of heterotopic pregnancy with tubal rupture. Journal of Clinical and Diagnostic Research, 2013; 7(12):3000-1.
2. Kamath MS, Aleyamma TK, Muthukumar K, Kumar RM, George K; A rare case report: ovarian heterotopic pregnancy after in vitro fertilization. Fertility and Sterility; 2010; 94(5): 1910.e9–1910.e11.
3. Umranikar S, Umranikar A, Rafi J, Bawden P, O'Sullivan B, Moors A; Acute presentation of a heterotopic pregnancy following spontaneous conception:a case report. Cases J, 2009;2:9369
4. Sohail S; Haemorrhagic corpus luteum mimicking heterotopic pregnancy. Journal of the College of Physicians and Surgeons Pakistan, 2005; 15:180-181.
5. Govindarajan MJ, Rajan R; Heterotopic pregnancy in natural conception. Journal of Human Reproductive Sciences 2008; 1(1):37–38.
6. Cheng PJ, Chueh HY, Qiu JT; Heterotopic pregnancy in a natural conception cycle presenting as haematomatra. Obstetrics & Gynecology, 2004; 104:195–8.
7. Lavanya R, Deepika K, Patil M; Successful pregnancy following medical management of heterotopic pregnancy. J Hum Reprod Sci, 2009; 2:35-40.
8. Henne DI; Ectopic Preg.Coexisting with Intrauterine Preg.Nig J Surg Res, 2000; 2:158 60.
9. Mital P,Acharya V, Hooja N, Sahai K; Heterotopic Ectopic Pregnancy.J Obstet Gynecol India ,2004; 54(5):505.
10. Bhargava S,Hooja N,Sharma M,Dadhich B, Aseri S ,Sharma N; Missed abortion with tubal ectopic pregnancy-presentation of heterotopic ectopic pregnancy-a diagnostic dilemma CIBTech Journal of Surgery, 2015;4 (2): 5-6.
11. Pschera H, Gatterer A; Laparoscopic management of heterotopic pregnancy a review. Obstet Gynecol Res, 2000; 26:157-61.