Case report - Heterotropic Pregnancy

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Abstract:
A 29 years old Etched female presented to 2nd March Hospital with vaginal bleeding. The patient was diagnosed by ultrasound as a case of coexisting pregnancy.

Introduction:
Heterotropic Pregnancy (coexisting pregnancy) it main intrauterine & extrauterine pregnancy. Ectopic pregnancy (EP) is defined as implantation of the fertilized egg outside the uterine cavity where it begins to grow. Both the prevalence and the incidence rates of EP are increasing (2.06%).\(^1,2\)
EP is the leading cause of maternal death during the first trimester, mainly in black women.\(^3\)
About 97% of EP occur in the fallopian tube.\(^4,5\)
Heterotropic pregnancies occur when there are coexisting intrauterine and ectopic pregnancy, the incidence varies from one in 100 to one in 30,000 pregnancies.\(^6\)
Here we present a case heterotropic pregnancy with a review of clinical presentation and management of ectopic pregnancy.

Case Report:
A 29 years-old Etched housewife was admitted to 2nd March Hospital in September 2003 with complaints of vaginal bleeding and lower abdominal pain for one day. She is G3 PO A1-1 (ectopic pregnancy) and she had a history of secondary infertility for seven years duration. She had history of left salpingectomy for ectopic pregnancy since 1997. History of spontaneous first trimester abortion for seven years ago. She presented with two months missed period after induction of ovulation by clomid. Clinically the patient is stable, blood pressure 115/75 mmHg, pulse 161 min regular, respiratory rate was 20 per minute. Per abdominal examination show mild tenderness in the right iliac fossa. Vaginal speculum examination shows mild vaginal bleeding with positive cervical motion. Uterus and right adnexal tenderness. Available investigations were done: pregnancy test positive, Hb 11.9g/dl, HCT 34%. Ultrasound examination revealed heterotropic pregnancy, intrauterine viable embryo (CRL=16.8^7 weeks + 4 days) another viable embryo in side the right fallopian tube (CRL=14.8 -> 7 weeks +3 days, gestational sac = 28mm).
The patient was transfer to Tripoli Medical Center (TMC) for further evaluation and treatment to preserve of right F. tube and intrauterine pregnancy.

Discussion:
The most common causes of EP are: pelvic inflammatory disease (PID),\(^7\) previous ectopic pregnancy (11-15%)\(^8\) intrauterine device (13%), tubal ligation and induction of ovulation.\(^9\)
EP must be differentiated from abortion, molar pregnancy, appendicitis and PID. Most cases of EP are found in women aged between 25 and 30 years.\(^5,10\)
A classic triad of symptoms is described for the patient who presents ruptured EP: abdominal or pelvic pain in 100% of the cases, amenorrhea is present in 85% of cases, vaginal bleeding occurs in 80% of case.\(^5\)
On physical examination, pulse rate is normal or may increase due to pain or anxiety; blood pressure may be normal or there may occur hypotension, if there is bleeding. Abdominal examination often reveals a surgical acute abdomen. Pelvic examination is typically characterized by pain on cervical motion and tenderness of the uterus (89%), adnexal tenderness 100%, and palpable adnexal mass 38%.\(^1,9\)
The most common findings detected by US are adnexal mass in 70% and pelvic intraperitoneal fluid in 50.2% of EP cases.\(^11\)
Transvaginal US is more accurate for the diagnosis of EP than transabdominal US.\(^12,13\)
Quantitative values for β-hCG may aid in the evaluation of the sonographic images.\(^14,15,16\)

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In about 80% cases of ectopic pregnancy, progesterone level is less than -15ng/ml. Diagnostic laparoscopy is a standard by which other diagnostic methods are measured; it allows direct evaluation of the pelvis and an early diagnosis of un-ruptured EP. In cases of severe extensive tubal damage salpingectomy is the appropriate procedure. Non-surgical (medical) management: recently, various conservative regimens for the treatment of EP. Methotrexate (MTX) being one of the most widely used drugs.

We transfer this case to TMC because:
1. We have a good experience about laparotomic salpingotomy but this operation carry a high risk of abortion so it should be avoided in this case
2. We have a very limit experience for laparoscopic operation.
3. To preserve functional right F. tubes because the left F. tubes was removed due to rupture previous ectopic pregnancy
4. To preserve viable intrauterine pregnancies as the patient complain from secondary infertility.

The best rout of surgical treatment is laparoscopic linear salpingotomy. I hope it was done in TMC.

References:
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