International Journal of Clinical Obstetrics and Gynaecology

ISSN (P): 2522-6614
ISSN (E): 2522-6622

www.gynaecologyjournal.com
2023; 7(1): 97-98
Received: 25-11-2022
Accepted: 27-12-2022

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Heterotopic pregnancy in a natural conception cycle: A case report

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DOI: https://doi.org/10.33545/gynae.2023.v7.i1b.1261

Abstract
Heterotopic pregnancy is defined as the coexistence of intrauterine and extrauterine pregnancy. Estimated incidence in general population is 1:30,000 (for a naturally conceived pregnancy). Incidence among patients with assisted reproductive technology is higher and is around 1:100 to 1:500. These patients are more likely to have spontaneous or medically induced abortion. We report a case of 35year old female G4 P3 L3 with 1 ½ months of amenorrhea presented in causality with pain abdomen and bleeding per vaginal in last 15 days with positive urine pregnancy test (UPT) report. USG shows a small 3 mm size hypoechoic focus with surrounding decidual reaction seen in endometrium– could be a gestational-sac, Left adnexa bulky with free fluid in pouch of douglas and in pelvic peritoneal cavity. Patient underwent laparotomy there was ruptured left tubal pregnancy with hemoperitoneum and left salpingectomy was done, dilation and evacuation of intrauterine pregnancy was done. The diagnosis of heterotopic pregnancy was confirmed on Histopathological report.

Keywords: Heterotopic pregnancy, amenorrhea, laparotomy, intrauterine pregnancy

Introduction
Heterotopic pregnancy is defined as the coexistence of intrauterine and extrauterine pregnancy [1]. Estimated incidence in general population is 1:30,000 (for a naturally conceived pregnancy) [2]. Incidence among patients with assisted reproductive technology (ART) is higher and is around 1:100 to 1:500. Diagnosed from 5-34 weeks of gestation with up to 70% diagnosed between 5- 8 weeks, 20% between 9-10 weeks and 10% >11 weeks of gestation. These patients are more likely to have spontaneous or medically induced abortion. Risk factors are assisted reproductive technology (ART), multiple embryo transfer and ovulation induction, pelvic inflammatory disease (PID), Previous ectopic pregnancy, Prior tubal surgery. Clinicians should always keep Heterotopic pregnancy in the differential diagnosis in a reproductive patient with abdominal pain and sign and symptoms of ectopic pregnancy. Early timely diagnosis is critical to safeguard intra uterine pregnancy and avoid maternal morbidity and mortality due to ectopic pregnancy.

Case
A 35-year-old female G4 P3 L3 with 1 ½ months of amenorrhea was presented in causality with pain abdomen and bleeding PV in the last 15 days with positive UPT report. Patient had no risk factors for ectopic pregnancy. On per vaginal (PV) examination mass was felt in left fornix. USG finding shows a small 3 mm size hypoechoic focus with surrounding decidual reaction seen in endometrium– could be a Gestational-sac, endometrium thickness (ET) 16 mm. Left adnexa bulky with free fluid in pouch of douglas (POD) and in pelvic peritoneal cavity (Figure-1). Provisional diagnosis of a heterotopic pregnancy with ruptured left ectopic was made. Patient underwent laparotomy, there was ruptured left tubal pregnancy with hemoperitoneum and left salpingectomy was done, dilation and evacuation of intrauterine pregnancy was done. The diagnosis of heterotopic pregnancy was confirmed on HPR report.

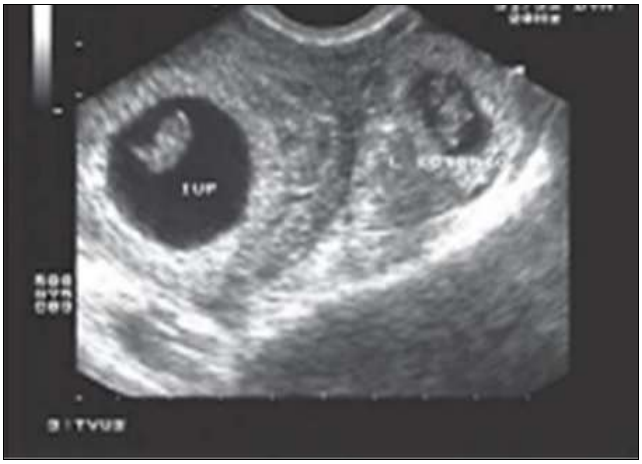

Fig 1: Abdominal ultrasound shows features of intrauterine as well as ectopic pregnancy.

Discussion

The detection rate of heterotopic pregnancy can vary from 41 - 84% with trans vaginal sonography (TVS) scan [3]. Diagnostic role of serum beta HCG in Heterotopic pregnancy is debatable. A diagnosis of pseudo sac should be made with caution as even in the presence of pseudo sac there can be high false positive diagnosis of an ectopic pregnancy. Sometimes the presence of a haemorrhagic corpus luteum can confuse and delay the diagnosis of heterotopic pregnancy. In this case the diagnosis of heterotopic pregnancy was accurately made with the use of transvaginal ultrasound, which allowed for timely diagnosis and management before grave consequences occurred. Intraoperatively, the ruptured left ectopic pregnancy was readily noted with the confirmation of a simultaneous intrauterine pregnancy. Patient manage safely with left salpingectomy and, dilation and evacuation of intrauterine pregnancy was done.

Conclusion

Clinicians should always keep Heterotopic pregnancy in the differential diagnosis in a reproductive patient with abdominal pain and sign and symptoms of ectopic pregnancy. A high index of suspicion in women is needed for early and timely diagnosis. Management with laparoscopy or laparotomy can result in a favourable obstetrical outcome. Early timely diagnosis is critical to safeguard intra uterine pregnancy and avoid maternal morbidity and mortality due to ectopic pregnancy.

Conflict of Interest

Not available

Financial Support

Not available

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How to Cite This Article
Sharma D, Neelam, Banerjee KP. Heterotopic pregnancy in a natural conception cycle: A case report. International Journal of Clinical Obstetrics and Gynaecology. 2023;7(1):97-98