Abstract:
Heterotopic pregnancy has been found in various forms but is still a rare event in spontaneous conception cycles with incidence of 1 in 30,000 pregnancies. Incidence has been increasing with assisted reproductive technologies to 1 in 7000 to 1 in 900 with clomiphene citrate. We report a case of a 36 yrs old patient who was treated for heterotopic pregnancy. She was a G3 P1 L 1 A1 with H O 2 months amenorrhea who underwent manual vacuum aspiration with curettage at a private clinic. She presented to our institution in a state of shock. Laparotomy was proceeded suspecting ruptured ectopic pregnancy and was found to be left side ruptured cornual pregnancy. Salpingectomy was done.

Keyword: Heterotopic pregnancy, Salpingectomy

Introduction: Heterotopic pregnancy is defined as simultaneous occurrence of both intrauterine and extrauterine pregnancies. It can be a life threatening condition and can be easily missed with the diagnosis being overlooked.

They can pose a diagnostic dilemma because an early transvaginal ultrasound may not pick up an extra-uterine gestational sac in all cases or a sonologist may miss the diagnosis after confirming an intrauterine gestational sac.

Case report:
6 yrs old G3P1L1A1, previous forceps delivery, known case of Rheumatic heart disease, with regular menstrual cycles and last menstrual period on 19/7/12 referred from private clinic as a case of suspected ruptured ectopic pregnancy in a state of shock. Patient attended a private clinic 20 days back with H/O 2 months amenorrhea for termination of pregnancy. Urine Pregnancy Test done was positive. Ultrasound showed single live intrauterine pregnancy of gestational age 6 weeks. Manual Vacuum Aspiration with check curettage was done and patient was discharged. Patient had on and off abdominal pain for which she was treated for gastritis. Meanwhile the histopathological reports were consistent with products of

A RARE CASE OF HETEROTOPIC PREGNANCY

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On 2/11/2012 patient developed severe abdominal pain, giddiness and collapsed in the private clinic. From there she was referred to our institution as suspected Ruptured Ectopic gestation. Initial resuscitation was done. On examination, Patient was conscious, oriented, drowsy, responding to oral commands. Pallor ++ Vitals – Pulse rate- 110/min, BP- 70/40 mmHg Other System Examination – Normal Abdomen Examination: Abdomen distended, tense, and diffuse tenderness present Per Vaginal Examination – Movement of cervix painful, fornicial tenderness was present Per Vaginal Examination – Normal Abdomen Examination: Abdomen distended, tense, and diffuse tenderness present Per Vaginal Examination – Normal Abdomen Examination: Abdomen distended, tense, and diffuse tenderness present Per Vaginal Examination

INTRAOPERATIVE PICTURE

FETUS AND PLACENTA
Discussion:
Heterotopic pregnancy was first described by Duverney in 1708. Synonym: Combined Ectopic Pregnancy, Multiple Sited Pregnancy, Coincident Ectopic Pregnancy. Incidence: Of spontaneous heterotopic pregnancy – 1 in 30000 pregnancies, Following ART – 1 in 7000 pregnancies, following use of clomiphene citrate 1 in 900 pregnancies. Pathogenesis: Risk factors same as that of ectopic pregnancy. Increased incidence of heterotopic in ART is due to multiple ovulation, associated tubal malformation/ damage, hydrostatic force used in embryo transfer. Clinical Presentation: 85% presented so far with abdominal pain and 13% with hypovolemic shock and tenderness. Treatment: Laparoscopy or Laparotomy with minimal manipulation of the uterus in case of rupture ectopic. In the absence of rupture, medical management like local injection of KCl can be advocated followed by conservative management of intrauterine pregnancy. Currently there is insufficient evidence to recommend any single modality of treatment and decision should be undertaken depending on clinical presentation.
surgeon’s expertise, side effects and patient preference. Conclusion: As far as this case is concerned, heterotopic was not suspected at initial presentation and later patient presented with acute abdominal pain and intraperitoneal hemorrhage. Finding of intrauterine gestational sac led to false reassurances. So THINK OF AN ECTOPIC, LOOK FOR AN ECTOPIC, RULE OUT AN ECTOPIC EVEN WHEN INTRAUTERINE SAC IS CONFIRMED. Similarly if patient has ongoing abdominal pain or pelvic pain with confirmed intrauterine sac or following abortion, heterotopic is to be ruled out.

References: