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## **CASE REPORT**

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### **Heterotopic pregnancy a case report**

**TL MAGWALI, B GUZHA**

#### **Abstract**

A 27 year old patient was admitted with heterotopic pregnancy. Ultrasound scan done by her general practitioner had shown a 14 week viable intra-uterine pregnancy and fluid in the paracolic gutters. An

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exploratory laparotomy was done and she was found to have a ruptured right-sided ectopic pregnancy. Right partial salpingectomy was done. She had an uneventful post operative course. Ultrasound scan done at 18 weeks showed that the foetus was growing well.

### Introduction

A heterotopic pregnancy is the presence of an intra-uterine pregnancy together with another pregnancy or pregnancies in one or more extra-uterine sites.<sup>1</sup> It was first described by Duverney in 1708.<sup>2</sup> It is a rare complication of pregnancy with a quoted incidence of one in 30 000 pregnancies.<sup>1,3</sup> The incidence of heterotopic pregnancy has, however, gone up due to the increasing use of assisted reproduction techniques. For women who have had assisted reproduction the incidence of heterotopic pregnancy is quoted as one in 100 pregnancies.<sup>4</sup>

### Case Report

The patient was a 27 year old *Para 1 Gravida 2*. She had a normal vaginal delivery in 2006. There was no history of subfertility or episodes of pelvic inflammatory disease. She was not sure of the date of her last menstrual period. She presented with a two day history of lower abdominal pain and vomiting. She also complained of chills and rigors for two days. There was no dysuria or cough. There was no history of vaginal bleeding.

On examination she was not pale, was afebrile and was haemodynamically stable. The abdomen was not distended. She was tender in the right lower quadrant of the abdomen but had neither guarding nor rebound tenderness. She was also tender over McBurney's point. On pelvic examination the cervix was soft and long with a closed external os. There was mild cervical excitation tenderness and tenderness in the right adnexal area. There were no masses felt in either adnexal areas. The uterus was bulky and was about 15 weeks' size.

Full blood count showed a haemoglobin level of 9.5g/dl and a white cell count of  $12.3 \times 10^3/L$ . Her general practitioner had sent her for an ultrasound scan before referral. This had shown a viable 14 week intra-uterine pregnancy with an expected date of delivery of 15 October 2008. The scan also showed fluid in the paracolic gutters but no masses in the adnexal areas. A provisional diagnosis of heterotopic pregnancy with a ruptured ectopic component was made. The differential diagnosis was acute appendicitis.

She was prepared for exploratory laparotomy. At laparotomy a haemoperitoneum of about 200mls was found and she had a bulky uterus of approximately 15 weeks. She had a ruptured right ampullary ectopic pregnancy. A right partial salpingectomy was done. The right ovary, left ovary and left fallopian tube were normal. The right fallopian tube with ectopic pregnancy and the bulky uterus are shown in Figure 1 below. Post operative recovery was uneventful and she

was discharged home on the fifth post operative day. She was well at review on the 12<sup>th</sup> day after discharge. She was seen with a new ultrasound scan six weeks from the day of the laparotomy. This showed that the foetus was growing well and there were no abnormalities of the foetus seen. Histology of the right fallopian tube confirmed ectopic pregnancy. She then moved back to her home city to continue prenatal care there.

Figure 1: The right fallopian tube with ectopic pregnancy and the bulky uterus.



### Discussion

The presence of an intra-uterine pregnancy often delays the diagnosis of the ectopic part as noted by Chandra *et al* in a case report.<sup>5</sup> Most heterotopic pregnancies are diagnosed in the early or middle first trimester.<sup>1</sup> The diagnosis in our patient was made in the early second trimester. The patient may present with lower quadrant abdominal pain with or without other clinical features of intraperitoneal haemorrhage depending on whether the ectopic component of the heterotopic pregnancy is ruptured or not. Spiff *et al* recommend evaluation of all women with lower abdominal pain in early pregnancy with ultrasound scan especially when conception has resulted from assisted reproduction technology.<sup>6</sup>

Our patient presented with rupture of the ectopic component although she was haemodynamically stable despite having a significant haemoperitoneum. It has been demonstrated that women with heterotopic pregnancy are more likely to present with rupture and signs of intraperitoneal haemorrhage compared to those with just an ectopic but without an intra-uterine pregnancy.<sup>7</sup>

Treatment is by laparotomy with salpingectomy especially where there is significant haemoperitoneum like in the patient presented here. Laparoscopic

salpingectomy or salpingostomy has been used successfully in some reported cases.<sup>1</sup> When the ectopic component is unruptured successful treatment has been achieved by instillation of potassium chloride or a small dose of methotrexate into the gestation sac under ultrasound guidance.<sup>8,9</sup> There have been numerous reports of continuation of the intra-uterine pregnancy after treatment for the ectopic part with delivery of a healthy baby or babies.<sup>10</sup>

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