

## CASE REPORT

### THE JOY OF UNFOUNDED PREGNANCY- HETEROTROPIC SPONTANEOUS PREGNANCY: A CASE REPORT

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**ABSTRACT:** Spontaneous heterotopic pregnancy is a rare clinical condition in which intrauterine and extra uterine pregnancies coexist. It can be a life threatening condition and can be easily missed with the diagnosis being overlooked. Heterotopic pregnancy occurs in 1 in 30,000 of spontaneous pregnancies though it is becoming commoner with assisted reproductive techniques. A 24 years old female was referred as a case of? Ruptured Ectopic pregnancy at POG four weeks and four days with acute pain abdomen and bleeding per vaginum for 2 days with ultrasound suggestive of ruptured ectopic with normal uterus. Exploratory laparotomy with left salpingectomy was done. She presented 3 months later with history of amenorrhoea since surgery for ectopic pregnancy and was found to have an enlarged uterus of 16 weeks size, corresponding to missed cycle of ectopic pregnancy (By dates) and ultrasound showing live fetus of 16 weeks. Thus practitioners carrying out salpingectomy for ruptured ectopic pregnancies should bear in mind the plausibleness of heterotopic pregnancy in order to properly handle the uterus.

**KEYWORDS:** Heterotopic pregnancy, spontaneous, ectopic, laparotomy, salpingectomy.

**INTRODUCTION:** Defined as presence of multiple gestations, one being in the uterine cavity and the other outside uterus, commonly in fallopian tube and uncommonly in the cervix or ovary.<sup>1,2,3</sup>

**CASE REPORT:** 24 years old female was referred as a case of? Ruptured Ectopic pregnancy at POG four weeks and four days (By dates). She was married for last 3 years and it was her second pregnancy, first being normal vaginal delivery of a live healthy baby.

There was history of acute pain lower abdomen for last two days, not relieved by analgesics; Bleeding per vaginum for last two days, soaking one pad per day and an episode of fainting in the morning.

Urine pregnancy test was positive.

USG at peripheral centre showed ruptured ectopic pregnancy with left adnexal mass with echogenic free fluid in pelvis. Uterus was normal in size with normal midline echopattern and endometrial thickness of 8.1 mm. Bilateral ovaries could not be visualized.

On general examination, she was quite pale and looking unwell. Her pulse was 110 beats/min, thready and low volume. Her blood pressure was 100/ 66 mm of Hg.

On per abdomen examination, there was mild distension and tenderness in the left iliac fossa.

On per speculum examination, there was brown colored discharge with cervix and vagina healthy.

On per vaginum examination, uterus was anteverted, bulky and soft with marked tenderness in left fornix, palpable left adnexal mass with cervical motion tenderness present.

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Ultrasound at our institute showed suspicious heterogenous mass in left adnexa of 3.4x3.2 cm; normal sized uterus with endometrial thickness of 16mm. and no intrauterine gestation sac.

There was mild echogenic free fluid in abdomen and pelvis.

**She was prepared for exploratory laparotomy. Intraoperatively, there was:**

- Hemoperitoneum-800c.c. fresh blood.
- 50gms clots.
- Left ruptured (Isthmic) tubal ectopic pregnancy.
- Left ovary grossly normal.
- Right tube and ovary normal.
- Uterus normal size, congested.

Left salpingectomy was done followed by peritoneal toileting.

One unit of whole blood was transfused intraoperatively.

Her post-operative period was uneventful and she was discharged after suture removal on day 5 postoperative.

Histopathological examination showed fallopian tube fragment showing features of decidualisation thus suggesting ectopic gestation.

She did not report for follow up as advised and reported to OPD after three months. She had history of amenorrhoea since surgery for ectopic pregnancy and was found to have an enlarged uterus of 16 weeks size, corresponding to missed cycle of ectopic pregnancy!

Urgent USG at our institute showed intrauterine pregnancy corresponding to 16 weeks POG and normal fetus.

She had regular antenatal visits at our institute and then normal vaginal delivery of healthy baby weighing 2500gm.

**DISCUSSION:** Heterotopic gestation, although fairly common with assisted reproductive techniques, is very rare in natural conception.<sup>4</sup>

The first reported Heterotropic Pregnancy was by Duverney (1708). It was an Incidental finding of intrauterine pregnancy while doing an autopsy of a patient who died due to ruptured ectopic pregnancy; Cause being fertilization of two ova (Superfetation).

It is becoming more common following assisted conception techniques for subfertility.<sup>5</sup> Heterotopic pregnancy occurs in 1 in 30, 000 of spontaneous pregnancies, 1 in 900 in clomiphene citrate induced pregnancies, and rises to 1% in assisted reproduction.<sup>6</sup>

Its diagnosis is often delayed and requires high index of suspicion because history, clinical symptoms and signs, physical examination, laboratory & ultrasonographic findings, all are generally nonspecific.

**Suggestive Signs and Symptoms:**

- Pain after spontaneous or induced abortion, two corpora lutea detected during USG, absence of vaginal bleeding after laparotomy for ectopic pregnancy,
- Lateral location of gestational sac on USG.
- Fluid in uterus and unpredictable quantitative HCG levels.

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In Management (Contentious), our aim is to excise the ectopic component while maintaining the intrauterine gestation.

Where ultrasound is not always available, practitioners carrying out salpingectomy for ruptured ectopic pregnancies should bear in mind the plausibility of heterotopic pregnancy in order to properly handle the uterus.<sup>7</sup>

Options could be laparoscopic salpingectomy, laparotomy in the hemodynamically unstable patient and Conservative management for unruptured ectopic pregnancy along with other favourable factors.

Quantitative measurement of HCG should be done and she should be advised for vigilance during follow up. There should be better imaging technology and trained personnel availability for high risk emergency cases.

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