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Case Report

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HETEROTOPIC PREGNANCY FOLLOWING SPONTANEOUS CONCEPTION: A CASE REPORT

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ABSTRACT

Heterotopic pregnancy is a rare event combining intra and extrauterine pregnancy. It can occur in the absence of any predisposing risk factors. We report a case of a 32-year-old woman who presented at 6 weeks of gestation with lower abdominal pain. Transvaginal ultrasonography objectified simultaneous extra and intrauterine pregnancy. An urgent laparotomy was performed confirming a ruptured ectopic pregnancy in the right fallopian tube. Preservation of the intrauterine pregnancy was obtained with vaginal delivery of a healthy boy. Increasing awareness of this rare entity among clinicians can help in early diagnosis and treatment with a great chance of a favorable obstetric outcome.

KEYWORDS: spontaneous conception; heterotopic pregnancy; ultrasound; surgery.

INTRODUCTION

Heterotopic pregnancy (HP) is a rare clinical condition in which extrauterine and intrauterine pregnancies (IUP) occur at the same time. It can follow an assisted or exceptionally, a natural conception cycle. Due to difficult preoperative diagnosis, it can be dangerous for mother and the simultaneous IUP. The authors present a case of a HP following spontaneous conception which was managed successfully in our department.

CASE REPORT

A 32-year-old Moroccan woman, gravida 2, parity 1, presented in our department with the chief complaint of lower abdominal pain appeared 48 hours before. At this time, the patient was pregnant at 6th week of gestation. She conceived spontaneously and she had no history of pelvic inflammatory disease (PID). Clinical examination showed mild tenderness at the right lower abdomen with no bleeding from the uterine cervix. Transvaginal ultrasonography objectified simultaneous intrauterine and ectopic pregnancy according to 6 weeks of gestation with current cardiac activity of both embryos **(Fig. 1)**. Patient was consented for an operative laparotomy few hours later. A total of 200 ml of hemoperitoneum was aspirated. The uterus was enlarged according to the gestational age. The left annex and right ovary were normal with a ruptured ectopic pregnancy in the ampullary region of the right fallopian tube. A right salpingectomy was performed and the material was sent for histological examination confirming chorionic villi. Nicardipine (Loxen®) was used for tocolysis. The IUP proceeded well with vaginal delivery, at term, of a healthy boy.

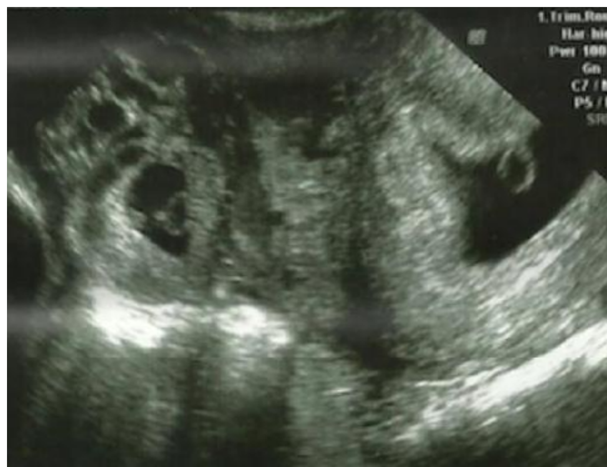

Figure 1: Transvaginal ultrasound showing simultaneous intrauterine and ectopic pregnancy at 6 weeks of gestation.

DISCUSSION

HP was first described in 1708 as an autopsy finding.[1] It has been traditionally regarded as a very rare event with an estimated incidence between 1/8000 and 1/30.000 pregnancies.[2] It mostly happens with known risk factors notably assisted reproductive techniques, ovulation induction, and history of PID or ectopic pregnancy. Our patient did not have any of the known risk factors in addition of endometriosis or tubal anomalies according to peroperative exploration. In HP, the ectopic pregnancy

can occur in different sites (fallopian tube, abdomen, uterine cornua, cervix, cesarean scar, ovary), but the fallopian tube is the most frequent reported site (72%).[3] Clinical features of HP can vary widely from asymptomatic to abdominal pain, which is seen in about 82.7% of cases, adnexal mass and vaginal bleeding.[4] On ultrasound, the identification of a live embryo within a gestational sac outside the uterus with an IUP is the gold standard for the diagnosis of HP, as was in the present case, but rare. Some authors recommend MRI in cases of high suspicion of ectopic or HP, where transvaginal sonography does not point to the accurate location of pregnancy.[5] Management of HP remains controversial. The majority of the reported cases are treated by surgery via laparoscopy or laparotomy. The choice between conservative or radical treatments may be difficult. A review demonstrated no difference in survival rates of the IUP after salpingotomy or salpingectomy for tubal ectopic pregnancy.[6] During surgery, the gravid uterus should be handled carefully to avoid uterine irritability and postoperative spontaneous abortion. The use of prophylactic tocolysis during and after surgery, for prevention of uterine contractions, still debatable by several authors.[3] Medical management using in situ injection of potassium chloride or hyperosmolar glucose might be a different approach for this entity; however, since the risk of rupture still exist, close monitoring of clinical symptoms and repeated ultrasounds are essential.

CONCLUSION

HP should always be considered in patients with abdominal pain and an IUP**.** Surgical approach with peroperative tocolysis should be preferred to preserve the intrauterine pregnancy.

Conflict of interest: None declared.

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