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Case Report

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Heterotopic Pregnancy: A Case Report of Retrospective Diagnosis Following Surgical Treatment

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ABSTRACT

Introduction: Heterotopic pregnancy is a rare occurrence. Very few clinicians may come across heterotopic gestations during their careers. It is a difficult condition to diagnose. It can lead to maternal mortality.
Case presentation: I present a case of a 27-year-old patient who presented to me with signs and symptoms of a ruptured ectopic pregnancy. Prompt laparotomy was done and a left tubal ectopic pregnancy was found with a 1.5 litres of hematoperitoneum. The patient requested premature discharge from hospital and on follow-up turned out to be having a viable intrauterine pregnancy. A retrospective diagnosis of heterotopic pregnancy was then made.
Conclusion: The diagnosis of a heterotopic pregnancy can be difficult to make. In this case where laboratory, radiological and blood transfusion services are not readily available, prompt surgery based on a clinical picture was life-saving and allowed the intrauterine pregnancy to progress.

KEYWORDS: Heterotopic pregnancy; Catastrophic hemorrhage; Maternal demise; Laparotomy.

INTRODUCTION

Heterotopic gestation defines the co-existence of both intrauterine gestation and an ectopic gestation commonly in the fallopian tube and uncommonly in the cervix or ovary.[1,2] The incidence is estimated to be 1:30,000 in spontaneous pregnancies.[3] Pelvic inflammatory disease is believed to one of the aetiological factors associated with ectopic gestations. It can also occur in patients without any risk factors.[3] Heterotopic gestation can follow natural conception[1] or assisted reproductive techniques like ovulation induction.[4] It can occur up to 10-15% of all ectopic gestations following *in vitro* fertilisation.

CASE REPORT

A 27-year-old, para 1 gravida 2, was referred to me by a casualty officer. She was complaining of intermittent lower abdominal pains on and off for 2 weeks. She had done a pregnancy test and it was positive. She said that she was about 5 weeks pregnant. The pain worsened of late and she was now complaining of dizziness too. She was married and worked as a temporary primary school teacher. She had no significant past medical, surgical or gynecological history. Initial examination revealed a pulse of 51 b/min, BP 101/50, and a temperature 34 ˚C. She was pale and with a very tense and tender lower abdomen. The cervical os was closed with slight blood on the glove and the uterus was bulky. She was resuscitated with crystalloid intravenous fluids and blood sent for X-match and full blood count. She was counselled on her condition and the need for prompt surgery. She asked me why I was going to operate her without doing any ultrasonography on her. I remarked that she was bleeding internally from a suspected tubal pregnancy, and that any delay would compromise her life. Thankfully she did agree and gave me the consent. Her results from the full blood count were Hb 9, WBC 11.2 and Platelet count 98.

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At laparoyomy, a 1.5 litres of hematoperitoneum was found with on-going hemorrhage from the fimbrial end of the left fallopian tube which had an ectopic gestational sac imbedded in it. A left salpingectomy was done and the abdomen was cleaned with saline. The specimen was sent for histological examination. Post-operatively the patient remained stable and did not need any blood transfusion. She recovered promptly and requested to go home on day 2 post-operatively. Hematinics and antibiotics were prescribed for her. She was instructed to rest at home and to come for review in a week's time.

At review her histology results were now available and had confirmed a tubal ectopic gestation. Her wound was healing well and her next review was at 6 weeks post-operatively when we planned to discuss contraception and folic acid supplementation during her next pregnancy.

When she came at her 6 weeks review, she asked why her pregnancy test remained positive and her periods had not returned. I sent her for an ultrasound scan which revealed a viable intrauterine pregnancy of 15 weeks gestation. The diagnosis of heterotopic pregnancy was explained to her and she understood. Her pregnancy progressed well and she delivered vaginally at term a baby girl weighing 3000 g.

DISCUSSION

The diagnosis of heterotopic pregnancy is a very difficult one to make. Like all ectopic gestations, delay in the diagnosis may lead to catastrophic hemorrhage and maternal demise including the intrauterine fetus. The management of heterotopic pregnancy is the gold standard laparoscopy or Laparotomy.[5] In cases where there is a combination of an intrauterine pregnancy demonstrated by ulstrasonography and severe abdominal pains, clinicians should consider diagnostic laparoscopy without uterine instrumentation or laparotomy. This case needed no further delay as her health was at risk. During Laparotomy, she was indeed found to be hemorrhaging. If she had been sent for further tests she could have collapsed or needed blood transfusions. The survival rate of the intrauterine pregnancy with a favourable outcome is 50-60% of cases.[6]

CONCLUSION

Clinicians must remain vigilant in prompt management of suspected ectopic gestations, at times using clinical findings to institute life-saving surgery without waiting for tests as happened in this case. This is especially pertinent in resource-limited environments. Making a retrospective diagnosis in a live patient is better than making it during a post-mortem examination.

COMPETING INTERESTS

The author declares no competing interests exists.

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