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Tubal Abortion with Intact Intrauterine Pregnancy (A Heterotopic Pregnancy) Case Report

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The incidence of coexisting intrauterine and extrauterine pregnancy (heterotopic pregnancy) is 1:30000 pregnancies. Induction of ovulation with clomiphene and gonadotrophins may slightly increase the risk of multiple gestations as well as of ectopic gestation because of increased number of ova stimulated and altered tubal motility. The association of multiple pregnancy with ectopic gestation is not uncommon with introduction of I.V.F. & multiple embryo transfer techniques. We are reporting a case of tubal pregnancy along with normal intrauterine pregnancy who presented as a case of acute abdomen with intraperitoneal haemorrhage.

Mrs. P.K. aged 22 years married since 2 years ($G_2 P_0 A_1$) with h/o missed abortion 1½ years ago, treated for secondary infertility with clomiphene citrate (2 cycles) was admitted with h/o 2½ months amenorrhoea & acute pain in abdomen on 17/10/99. Her LMP was 05/08/99 EDD 12.05.2000. Pregnancy was confirmed by USG on 14/09/99 which showed 5.5 weeks intrauterine pregnancy. Patient was given conservative treatment including HCG injections in early pregnancy. Patient had spotting on 04/10/99 along with constipation and rectal tenesmus. USG showed viable foetus of 9.2 weeks gestation along with subchorionic haemorrhage. Conservative treatment along with mild laxative was given but the rectal tenesmus & mild pain off and on persisted inspite of treatment.

On 17/10/99 she developed severe pain in lower abdomen starting from the right side along with fainting sensation. Her pulse was 108/mt BP=120/70 mm of Hg Hb – 8.8gm%.

On P/A examination – No specific bulge in suprapubic region felt but signs of intraperitoneal bleeding were present as muscle guarding.

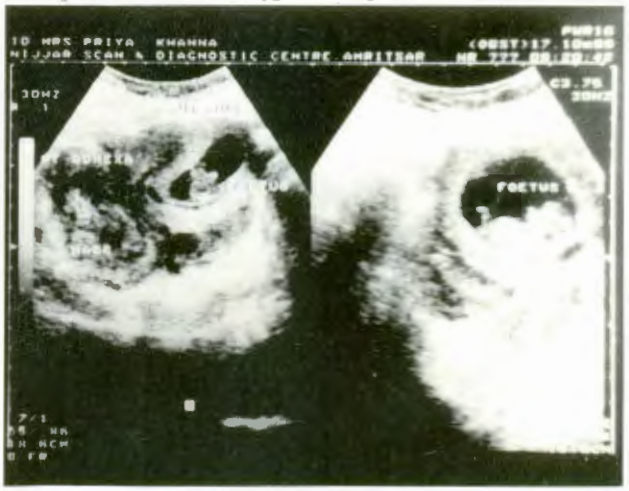

Fig 1: Ultrasound showing heterotopic pregnancy. Intrauterine viable foetus of 9.2 weeks gestation and extra uterine adnexal mass with gestational sac.

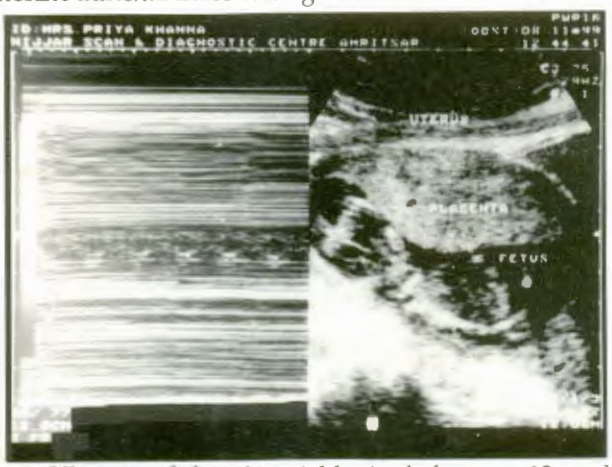

Fig II: Ultrasound showing viable single foetus at 13 weeks and 4 days gestation.

On P/V examination – Uterus enlarged to 10-12 weeks size, midposed, cervix soft, excitation sign +ve, right adnexal region was full. Brownish discharge was present.

Repeat USG revealed uterus showing 10.5 weeks viable foetus with subchorionic hematoma reaching the os. Amniotic fluid was normal. An ill-defined echogenic mass containing a sac like structure was seen in right adnexal region and fluid was observed in the pelvis, right paracolic gutter and Morrison's pouch. Echoes & septae were seen in it (? Blood) (Fig. 1). Diagnosis of heterotopic pregnancy was made. Taking into consideration the amount of fluid in the abdomen & acute symptoms, emergency laparotomy was planned. On opening the abdomen, peritoneal cavity was found to be full of freshly clotted blood (about 600cc), some organised blood was also found. Uterus was 12 weeks size. There was right sided intact tubal pregnancy (size 7cm x 4cm x 4cm) in the ampullary region & frank bleeding from tubal ostium was seen. Left tube and ovary were normal. Right sided salpingectomy was done. Clotted blood was removed from the peritoneal cavity. Post-operative period was uneventful. Conservative treatment for intrauterine pregnancy was continued. Repeat scan on 08/11/99 showed viable pregnancy of 13 weeks 4 days gestation (Fig. 2).

The dilemmas in our mind regarding this case are:

1. Whether HCG injections also supported the tubal gestation upto 10.5 weeks without rupture?
2. Whether doubling time for serum HCG has any value for diagnosis of tubal pregnancy in such situations inspite of early suspicion?
3. If ultrasonographic detection of adnexal mass was made at first visit, whether it would have changed the management considering the need of continuation of intrauterine pregnancy in view of her previous pregnancy wastage and how else the risk for spontaneous abortion of intrauterine pregnancy before 8 wks of gestation could be reduced in such a case?