Combined Intrauterine and Extrauterine Pregnancy (Case Report)

KOMBİNE OLMUŞ INTRAUTERIN VE EKSTRANTERİN GEBELİK (VAKA TAKDİMİ)

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SUMMARY

Objective: *To present a case of heterotopic pregnancy that has a very low incidence of 1 in 30000 pregnancies.*

Institution: *Dr.Zekai Tahir Burak Maternity Hospital*

Materials and Methods: A 40 years old woman, gravida 7, para 4, D&C 3 was admitted to the hospital with the complaint of severe abdominal pain radiating to rectum. Physical and pelvic examination and the transabdominal ultrasonographic (TAU) findings of a private radiologist led us to the diagnosis of extrauterine pregnancy. To control bleeding properly a D&C was carried out -as patient had no further desire of fertility- before proceeding with laparotomy. The left Fallopian tube was found to lodge a tubal pregnancy bleeding from its fimbrial end. Left salpingectomy and right tubal ligation was performed.

Findings: *Though it was distant to mind preoperatively, pathological examination of the D&C material and the surgical specimen revealed the presence of a heterotopic pregnancy.*

Results: *Patients with signs of acute abdomen, in whom an intrauterine gestation is confirmed, should be examined with the possibility of a concomitant extrauterine pregnancy in mind. Transvaginal ultrasonography is the most powerful and the best means of such a diagnosis.*

Key Words: Heterotopic pregnancy, Transvaginal ultrasonography, Transabdominal ultrasonography

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ÖZET

Amaç: 30000 gebelikte 1 gibi düşük bir insidansa sahip bir heterotopik gebelik olgusunu sunmak.

Çalışmanın Yapıldığı *Yer: Dr.Zekai Tahir Burak Kadın Hastanesi*

Materyal ve Metod: *40 yaşında, gravida 7, para 4, D&C 3 olan hasta, rektuma yayılım gösteren karın ağrısı şikayetiyle başvurdu. Hastanın genel ve jinekolojik muayenesi ile özel bir ultrasonografist tarafından yapılan transabdominal ultrasonografi tetkiki sonrasında ekstrauterin gebelik tanısı kondu. Laparotomiye geçmeden önce, çocuk isteği olmayan hastaya kanama kontrolü amacıyla D&C yapıldı. Laparotomide, sol tuba uterinada, fimbriadan kanayan ektopik gebelik saptandı. Sol salpenjektomi ve sağ tüp ligasyonu uygulandı.*

Bulgular: *Ameliyat öncesinde düşünülmemesine karşın, D&C ve ameliyat materyallerinin patolojik incelemesi sonucunda hastada heterotopik gebelik olduğu onaya çıkarıldı.*

Sonuç: *Akut batın bulguları olup intrauterin gebelik saptanan hastalarda, birlikte olması muhtemel bir ekstrauterin gebelik akıldan çıkarılmamalıdır. Tanıya ulaşmada transvajinal ultrasonografi en iyi ve güçlü yoldur.*

Anahtar Kelimeler: Heterotopik gebelik, Transvaginal ultrasonografi, Transabdominal ultrasonografi

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Combined intrauterine and extrauterine pregnancy is a rare event in obstetrics. A case of such a heterotopic pregnancy is presented.

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INTRODUCTION

Pregnancies occuring simultaneously in different body sites (heterotopic pregnancies) are rare conditions with an incidence of 1 in every 30 000 pregnancies (1). Of the 66 cases of combined pregnancies reported between 1966 and 1979, 4(6%) were ovarian and the rest (94%) were tubal (2).

The main predisposing factor for ectopic gestation is pelvic inflammatory disease (1) but recently due to the advent of techniques of assisted reproduction the incidence of simultaneous intrauterine and extrauterine

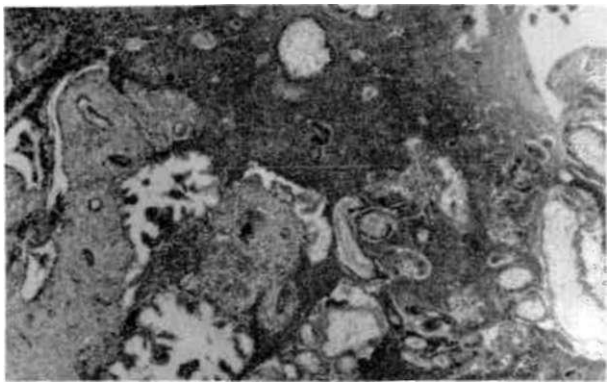

Fig. 1. Endometrial material. Normally appearing chorionic villi are demonstrated (H.Ex40)
Şekil 1. Endometrial materyal. Normal görünümlü kronik villuslar görülmektedir.

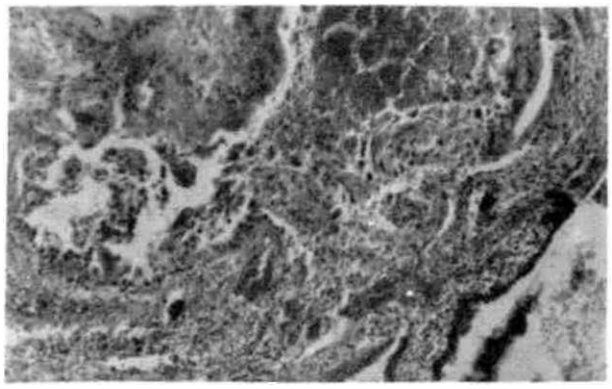

Fig. 2. Tubal pregnancy. Decidual reaction and trophoblastic cells in the mucosa of the tube (H.Exl 00)
Şekil 2. Tubal gebelik. Tüp mukozasında desidual reaksiyon ve trofobiyotik hücreler.

pregnancy has increased (1,2). The use of an intrauterine contraceptive device also seems to be an important factor, especially as regards to ovarian gestation. Endometriosis is another potential etiologic factor.

CASE HISTORY

G.D. a 40-year-old woman, gravida 7, para 4, D&C 3 was admitted to hospital due to severe abdominal pain radiating to rectum. Besides pain she also complained of vaginal bleeding and fatigue. She had irregular bleeding for about 7-8 months and 36 days has passed since her last menstrual period. Past history revealed nothing but an appendectomy 16 years ago. Gynecological examination revealed an intensive pelvic tenderness and a pelvic mass completely filling the rectouterine pouch. Slight vaginal bleeding was noticed. Ultrasonographic examination carried out before admission to the hospital by a private radiologist out of the hospital pointed out the suspicion of an extrauterine pregnancy.

These findings combined with the positive pregnancy test collaborated our suspicion further and as an aid to diagnosis culdocentesis was performed. Nonclotting blood in appreciable amount and developing tachycardia with decrement in patient's blood pressure (90/40 mmHg) led us to the decision of performing a emergency laparotomy. But before proceeding to laparotomy a D&C was carried out and the material was kept for pathological diagnosis.

About 400 cc. of coagulated and free blood was found in the abdomen. The uterus was slightly enlarged, the ovaries and the right fallopian tube were normal in apparance and there were no postoperative or postinflammatory adhesions in the pelvis. The left fallopian tube was found to lodge and extrauterine pregnancy in its ampullary region, actively bleeding from its fimbrial end. The tube was intact but in order to control hemorrhage properly and ad the patient had no desire of further fertility left salpingectomy and right tubal ligation with modified Pomeroy technique was performed. The patient had an uneventful postoperative period and was discharged from the hospital at sixth postoperative day.

Though a diagnosis of heterotopic pregnancy was distant to mind preoperatively, the pathological examination of the surgical specimen and the D&C material revealed as such (Fig. 1 and Fig. 2).

DISCUSSION

Heterotopic pregnancy (simultaneous intrauterine and extrauterine pregnancy) is an extremely rare clinical phenomenon occuring approximately 1 in 30 000 pregnancies or 1 in 2.000.000 live births (1). The incidence has increased in recent years (2).

No single factor is responsible for all ectopic gestations and probable that most cases are multifactorial in origin (3). Pelvic inflammatory disease, intrauterine contraceptive devices, use of various assisted reproductive techniques, endometriosis and previous abdominal surgery are the proposed risk factors (1).

None of the above factors but an appendectomy in the past history of the patient was present in our case. In most of the studies related with ectopic pregnancies it has been noted that 25-30% had undergone previous abdominal surgery, most commonly an appendectomy (4).

In our case though the findings were strongly suggestive of an extrauterine gestation, we didn't consider the possibility of a heterotopic pregnancy. The uterus was found to be slightly enlarged and we attiributed this to the multiparous status of the patient Also, the radiologist who carried out the ultrasonographic examination of the patient in a private office notified us about the gestation. This is in contrast with the findings of Mattox ans colleagues who stated that

ultrasonography is far less accurate to diagnose the associated ectopic pregnancy (5).

On the other hand, we mustn't forget the fact that a transabdominal not a transvaginal ultrasonography was carried out In our patient. The latter was found to be superior to former demonstration of heterotopic pregnancies (5).

In summary, we recommend routine ultrasonographic (preferably transvaginal) examination of all pregnant patients in the first trimester; especially the ones who carry a risk for ectopic/heterotopic pregnancy. Patients with signs of acute abdomen, in whom the diagnosis of an intrauterine gestation was confirmed, should be examined with the possibility of a concomitant extrauterine gestation in mind. As a noninvasive method of diagnosis transvaginal ultrasonography is the most potent weapon in our armamentarium for diagnosis of heterotopic pregnancy. Laparoscopy can be performed for confirmation, if suspicion exists.

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