SPONTANEOUS HETERO TOPIC PREGNANCY WITH TUBAL RUPTURE: REPORT OF A CASE

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SUMMARY
Spontaneous heterotopic pregnancy is a clinic entity that is seen very rarely. It is a life threatening condition and always must be kept in mind especially in intrauterin gestation with abdominal pain and the presence of intraabdominal fluid that is due to intraabdominal bleeding. Ultrasound is very important in diagnosis and the treatment choice is surgical modalities according to the severity of the case.

Key words: acute abdominal pain, spontaneous heterotopic pregnancy

ÖZET
Tubal Rüptürün Eşlik Ettiği Spontan Heterotopik Gebelik: Oluğ Sunumu
Spontan heterotopik gebelik çok az görülen klinik bir durumdur. Hayat tehdit eden bir durum olduğundan, özellikle karın ağrısı ile beraber intrauterin gebelik varlığında, intraabdominal kanama bağlı intraabdominal sывın bulunduğu hallerde akılda tutulmalıdır. Ultrasonografi teşhis için önemli olup, olayın ciddiyetine göre cerrahi tedavi modaliteleri seçilmelidir.

Anahtar kelimeler: akut karn, spontan heterotopik gebelik

INTRODUCTION
Spontaneous heterotopic pregnancy is a clinic entity that is seen very rarely. The first case was reported in 1708 as an autopsy finding(1). The incidence of heterotopic pregnancy is between 1/30000 and 1/8000 (2,3), but the incidence is increased with the using of assisted reproductive techniques and ovulation induction therapies(4,5).
We report a tubal heterotopic pregnancy in a spontaneous cycle which consulted in our clinic with the symptoms of acute abdominal pain.

CASE REPORT
A 28-year old para 1, gravida 2 woman with abdominal pain lasting for three days consulted in Ege University Faculty of Medicine, Department of Obstetrics and Gynecology, Izmir, Turkey. The patient was in 8th gestational week of a spontaneous pregnancy. She had no history of infertility, surgical operation or systemic disease. Abdominal examination revealed muscular rigidity, diffuse tenderness in lower abdominal quadrants and rebound tenderness mainly in the right lower quadrant. There were no vaginal bleeding. The uterus was corresponding to 8th gestational week and cervical
examination was painful at bimanual vaginal examination. It was seen simultaneously an extratereine right-tubal and intratereine pregnancy in vaginal ultrasound scanning. Cardiac activity was noted in both intratereine and extratereine fetuses. The CRL of intratereine fetus was 16 mm (8 weeks, 2 days) and the CRL of the extratereine one was 12 mm (7 weeks, 3 days). There were fluid and echogenities in rectavaginal pouch and around the parovarian spaces. The heart rate of the patient was 110 per minute and blood pressure was 110/60 mmHg. An emergent laparotomy was performed through a pfannenstiel incision. There were approximately 800 cc of haemoperitoneum in abdominal inspection. It was seen a ruptured extratereine pregnancy in right tube’s ampullary part. After aspiration of blood, a complete salpingectomy was performed to the right tube. A viable intratereine pregnancy was seen in postoperative 1st day ultrasound. Three units of blood an one unit of fresh-frozen plasma replaced to the patient perioperatively. She was discharged on the fourth postoperative day and followed-up regularly at our obstetrics clinic. She is now 24th weeks of gestation in October 2004 without any clinic problem.

DISCUSSION

There are many forms of heterotopic pregnancies. Some of these are bilateral tubal pregnancy, abdominal and intratereine pregnancy, twin tubal and intratereine pregnancy, intratereine and tubal pregnancy, intratereine and cornual pregnancy, intratereine and cervical pregnancy and intratereine and ovarian pregnancy (6,7). Heterotopic pregnancies are rare events (8,9). The incidence has increased with the widespread use of assisted reproductive techniques (10,11). There are several predisposing factors to heterotopic pregnancy which are identical to the predisposing factors of ectopic pregnancy; tubal damage after pelvic inflammatory disease, endometriosis or former tubal surgery are some of them.

It has been reported that 70% of heterotopic pregnancies were diagnosed between 5 and 8 weeks of gestation, 20% of them were diagnosed between 9 and 10 weeks and 10% after the 11th week (12). Clinical symptoms seemed not to be very helpful. Reece et al (13) defined four common presenting signs and symptoms according to their retrospective analysis of 66 heterotopic pregnancies. These are abdominal pain, adnexial mass, peritoneal irritation and an enlarged uterus. Transvaginal ultrasound should be used as an important diagnostic technique in the diagnosis of heterotopic pregnancy (14). Because of different rates of hCG and progesterone produced by heterotopic pregnancies, the hormonal algorithms for the diagnosis of ectopic pregnancy described previously can not be reliably used in this situation. Visualization of the heart activity in both intratereine and extratereine gestations by ultrasound makes the diagnosis certain. Although spontaneous heterotopic pregnancy is a rare situation, we could see it in our case.

In the management of a heterotopic pregnancy, a conservative approach is generally preferred to preserve the intratereine gestation (4). In case of rupture and haemoperitoneum, surgical therapy is imperative, as in our case (15). The standard treatment for ectopic pregnancy is surgery by laparoscopy or laparotomy. In our case, we preferred laparotomy because of the presence of massive intraabdominal haemorrhage. The local injection of potassium chloride to the intact tubal ectopic site is another treatment choice of heterotopic pregnancy (10). Methotrexate, RU486 or prostaglandins should not be used due to their potential adverse effects on the intratereine gestation (17).

In conclusion, spontaneous heterotopic pregnancy is a very rare but life-threatening condition that always must be kept in mind especially in intratereine gestation with abdominal pain and the presence of intraabdominal fluid that is due to intraabdominal bleeding.

REFERENCES


