

Research Journal of Pharmaceutical, Biological and Chemical Sciences

A Case Report on Heterotopic Pregnancy.

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ABSTRACT

Spontaneous heterotopic pregnancy is a rare clinical condition in which intrauterine and extra uterine pregnancies occur at the same time. It can be a life threatening condition because the diagnosis can be missed easily. Here a case of 33 years old G2P1L1 came with 2 months of amenorrhoea where pregnancy was confirmed and she was doing regular antenatal check up, came with C/O pain abdomen and bleeding per vaginum for past 3 days and patient was not diagnosed as heterotopic pregnancy. Patient was taken up for emergency laprotomy and was diagnosed ruptured tubal pregnancy with intrauterine pregnancy.

Keywords: Heterotopic, ectopic

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INTRODUCTION

Heterotopic pregnancy is the existence of 2 (or more) simultaneous pregnancies with separate implantation sites, one of which is ectopic [1]. The incidence is 1 in 30000 in pregnancies. It increases to 1 in 7000 in case of assisted deliveries [2, 3]. The diagnosis of heterotopic pregnancy is a challenge for obstretition.

CASE REPORT

Mrs. Punitha, 33yrs, MRD NO 492127, G2P1L1/Previous FTNVD/ GA-8WEEKS-2days of gestation came with complaints of severe abdominal pain for 3days and nausea. No H/O bleeding per vaginum .Patient was having regular 3/30 days of cycle with LMP 8.JAN.2014.PT had a first full term normal vaginal delivery and she was on Cu T for 5 years and removed 6 months back and conceived spontaneously after 4 months .Pregnancy was confirmed by urine pregnancy test. Patient was on folic acid tablets. At 2months of amenorrhoea she presented with pain abdomen and nausea. On examination patient general condition was good and conscious. patient had severe pallor ,vitals were stable .per abdomen-distended generalized tenderness(+)per vaginum :Cx downwards, uterus size can't be made out,movement of Cx not painful, external os patulous ,fullness(+)over all fornices.USG shows haemoperitoneum and SLIUG 8Weeks+2day according to CRL. patient was taken up for emergency laprotomy and proceed.

Procedure Emergency Laprotomy Proceeded and Partial Salpingectomy Done

INTRA OP FINDINGS

- UTERUS AROUND 8-10WEEKS
- LEFT OVARY AND TUBE RUPTURED ECTOPIC MASS SEEN AT THE AMPULLA ABOUT 6*4CMS.
- RIGHT OVARY AND TUBES NORMAL
- HAEMOPERITONEUM OF 1 TO 1.2 LITRES

Patient was transfused 2 units of packed cells

POSTOPERATIVELY

Patient was stable on the 6th post operative day, USG PELVIS showed absent Fetal heart rate and advised MTP. MTP done by medical method.post op period was uneventful and patient was discharged.

DISCUSSION

Heterotopic pregnancy is defined as the presence of multiple gestations, with one being in the uterine cavity and the other outside the uterus commonly in the fallopian tube and uncommonly in the cervix or ovary [4, 5, 6]. Spontaneous triplet heterotopic pregnancy has also been reported with two yolk sacs seen in one tube [7], and in another case an ectopic pregnancy in each tube with a single intrauterine gestation [8]. Heterotopic pregnancies are becoming more common following assisted conception techniques for subfertility [9], however spontaneous heterotopic pregnancies are quite rare [10]. The incidence quoted is 1 in 30,000 pregnancies [11]. The detection rate of heterotopic pregnancy can vary from 41 to 84% with transvaginal ultrasound scans [12,13].

The question however arises in women with spontaneous gestations who do not necessarily have early ultrasound scans. Women with previous ectopic pregnancy, tubal surgery or previous pelvic inflammatory disease may be at a higher risk and should be scanned at an early gestation to confirm the location of the pregnancy. if a patient continues to have ongoing abdominal or pelvic pain with a confirmed intrauterine pregnancy, one of the differential diagnoses should be heterotopic pregnancy. The reported gestational age at diagnosis of HP ranges from 5 to 20 weeks, with a mean of 8 weeks, give or take 3 weeks[14]., most cases of HP occur in the fallopian tube; other commonly affected sites include the cervix and a cesarean delivery scar[14].

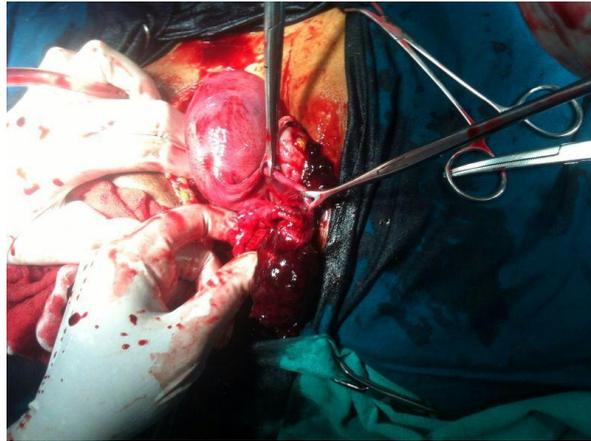


Figure 1



Figure 2



Figure 3

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