A CASE OF HETEROTOPIC, INTRAUTERINE AND INTRA ABDOMINAL PREGNANCY AT TERM

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ABSTRACT

This case report describes combined intrauterine and intra abdominal pregnancy. Case was presented in emergency where she delivered a dead macerated male baby. The abdominal pregnancy was diagnosed at Laparotomy done for 2nd twin. An alive female baby weighed 1800gm was delivered with good Apgar score. Both mother and baby were discharged on 7th post operative day in good condition. Heterotopic pregnancy at term is very rare only few cases have been reported.

Key words: Heterotopic , intra abdominal pregnancy, ectopic pregnancy

INTRODUCTION

Heterotopic pregnancy is defined as presence of intrauterine along with extra uterine pregnancy. This incidence of ectopic differs in different populations and the frequency of combine intrauterine and intra abdominal pregnancy is directly related to the frequency of ectopic pregnancy. Only few cases of Heterotopic pregnancy at term have been reported world wide[1]. Diagnosis of abdominal pregnancy is also very difficult even by high resolution ultrasound, the reported incidence for error ranges from 50 % - 90 %.[4] Early diagnosis and proper management has great impact on reducing morbidity & mortality. There is dilemma for the management of placenta, whether it should be removed or left in situ. If it is removed, the life threatening bleeding can occur, as was the case in this patient, or if placenta left behind then maternal morbidity and mortality significantly rises.

CASE REPORT

A 30 years old woman in her 3rd pregnancy with previous normal vaginal deliveries came in emergency after examination by a Dai. She had no antenatal check-up and no ultrasound was done during this pregnancy. She did not remember her last menstrual period (LMP) and gave history of 8 months amenorrhea. On arrival her pulse was 88/min, BP 110/70 mmHg and she was afebrile and no uterine contractions. On abdominal examination fundal height was 34 wks with transverse lie. Fetal heart sound (FHS) 142 beats/min. While doing her examination she expelled a dead macerated male baby of weight 1000gm with no obvious congenital anomalies. Placenta with membranes was also delivered afterwards.

After delivery when her abdominal examination was done, fundal height was 30 weeks with another fetus lying transversely. There were no uterine contractions and FHS were 144 beats/min. On pelvic examination, cervix was multiparous, presenting part was not palpable and there was moderate amount of bleeding. Her routine investigations and blood for cross match was sent. Blood group was A –ve. Her emergency cesarean section was planned. The lie of the fetus was confirmed by ultrasound. On opening the abdomen, via a pfannenstiel incision an alive fetus was found inside an intact amniotic sac within the abdominal cavity. There was no haemoperitoneum and small part of omentum was adherent to the sac which was clamped, cut and ligated. After amniotomy, a normal live female baby was delivered. It weighed 1800gm and had Apgar score of 4/10 and 6/10 at 1 and 5 minutes. Amazingly the baby had no deformity due to pressure. The uterus was 16 weeks size and pushed towards left. The placenta was attached to the right side of the uterus and fortunately was not attached to the intestines, while right fallopian tube and ovary were also adherent to the placenta. Due to massive hemorrhage her emergency hysterectomy was done along with removal of placenta & membranes adherent on the outer surface of the uterus.

Baby was shifted to neonatal unit. Post operative period was uneventful. Patient and baby were discharged on 7th post operative day in good

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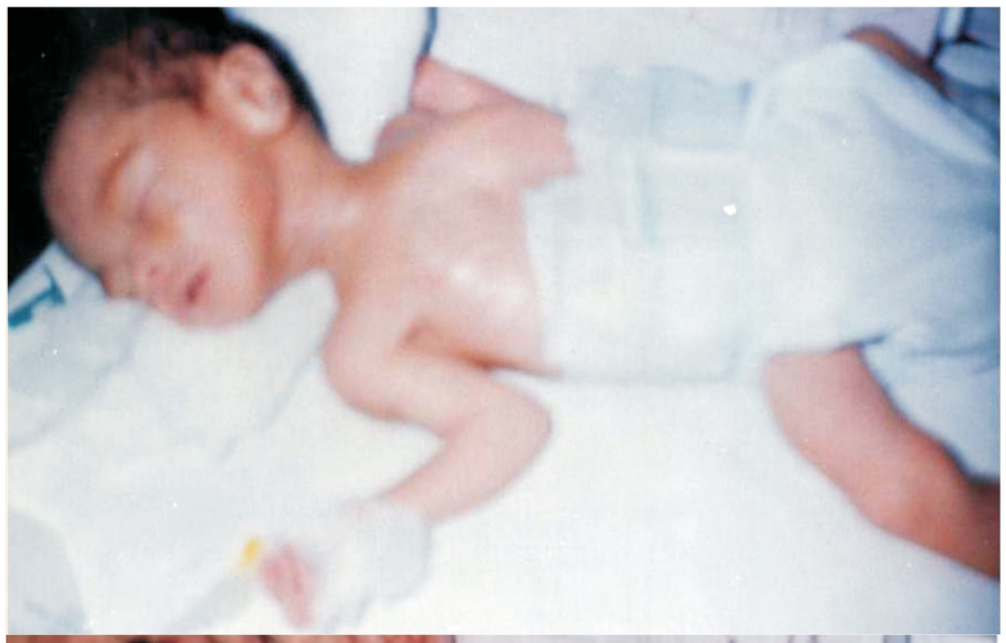
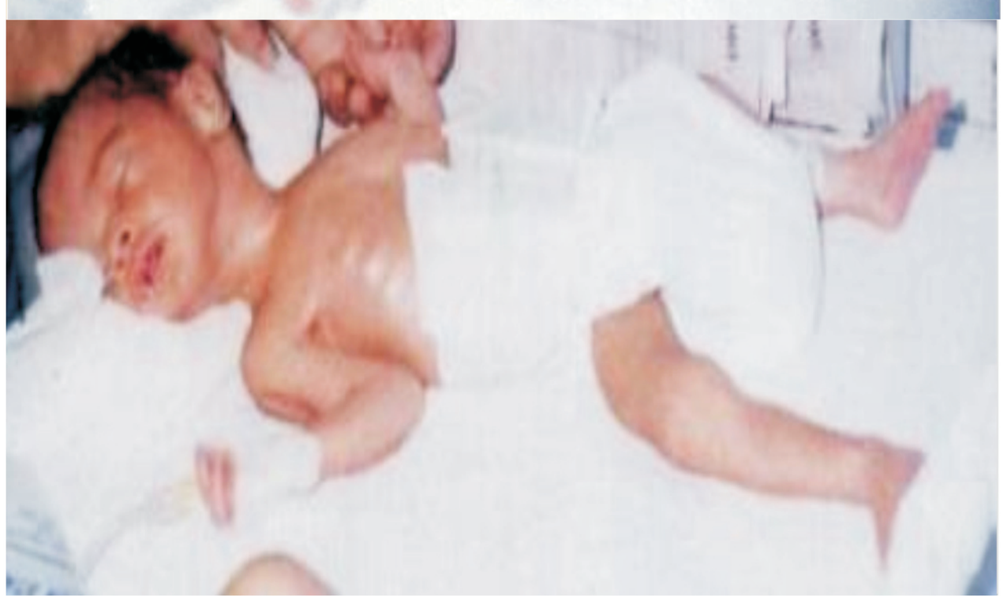
condition.

DISCUSSION

The combinations of intrauterine and extra uterine pregnancies in natural cycles are very rare event. The frequency is directly related to the frequency of ectopic gestation in the population[1], but now the number of cases appears to be increasing due to increasing use of assisted reproductive techniques with embryo transfer[2]. It is more commonly seen in patients of low socio-economic status and in developing countries, especially in rural areas ,presumably due to lack of diagnostic facilities, and poor utilization of medical care by pregnant woman[3]. The case reported here came from a rural area and had no prenatal care. Diagnosis of abdominal pregnancy continues to be a challenge, even under the best circumstances and with high resolution ultrasonography the diagnosis is often missed. The diagnostic error in the different series has range from 50-90%.[4]





However, magnetic resonance imaging (MRI) has been used successfully to compliment sonography in making an accurate preoperative diagnosis of abdominal pregnancy. In fact, MRI is considered as the gold standard for diagnosis.[3] The lateral view of X-ray of abdomen and pelvis showing fetal parts overlying the maternal spine is also helpful.[5] Elevated maternal serum alpha fetoproteins also raise the suspicion of an abdominal pregnancy.[6]

The case reported here surviving ectopic tubal pregnancy is rare but also described in literature for isolated ectopic pregnancies and for abdominal pregnancies.[7] Our patient has additional risk factor for heterotopic pregnancies, apart from tubal damage and assisted reproductive treatment. The incidence of heterotopic pregnancies is the highest in Africa but less frequently reported from Asia.[1]

Only three cases of heterotrophic pregnancies are reported in literature two were from Kitui District Hospital, Kenya and two from Tanzania.[5,8,9] If women had obstetrical ultrasound during antenatal period then one would be prepared to handle the complication of abdominal pregnancy and can save the uterus.

Controversy exists for the management of placenta, whether it should be removed or left in situ[4]. Uncontrollable haemorrhage occurs frequently during its removal. The worst haemorrhage near to catastrophe has been reported by Ramachandran[10], as happened in our patient, four pints of blood and six units of haemaccel were transfused. If the placenta is left behind then the maternal morbidity and mortality significantly rises with common complications like haemorrhage, sepsis, abscess formation, ileus, intestinal obstruction and severe abdominal pain.[11]

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Try not to become a man of success but rather to become a man of value

(Albert Einstein)