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# SPONTANEOUS HETEROTOPIC 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: Olgu Sunumu

*Spontan heterotoplik gebelik çok az görülen klinik bir durumdur. Hayatı tehdit eden bir durum olduğundan, özellikle karın ağrısı ile beraber intrauterin gebelik varlığında, intitraabdominal kanamaya bağlı intraabdominal sıvının bulunduğu hallerde akılda tutulmalıdır. Ultrasonografi teşhis için önemli olup, olayın ciddiyetine göre cerrahi tedavi modaliteleri seçilmelidir.*

**Anahtar kelimeler:** *akut karın, 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 spontaneus 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

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examination was painful at bimanuel vaginal examination. It was seen simultaneously an extrauterine right-tubal and intrauterine pregnancy in vaginal ultrasound scanning. Cardiac activity was noted in both intrauterine and extrauterine fetuses. The CRL of intrauterine fetus was 16 mm (8 weeks, 2 days) and the CRL of the extrauterine one was 12mm (7 weeks, 3days). There were fluid and echogenities in rectovaginal pouche and around the paraovarian spaces. The heart rate of the patient was 110 per minute and blood pressure was 110/60 mmHg.

An emergent laparatomy was performed through a pfannenstiel incision. There were aproximately 800cc of haemoperitoneum in abdominal inspection. It was seen a ruptured extrauterine pregnancy in right tube's ampullar part. After aspiration of blood, a complete salphingectomy was performed to the right tube. A viable intrauterine pegnancy 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 intrauterine pregnancy, twin tubal and intrauterine pregnancy, intrauterine and tubal pregnancy, intrauterine and cornual pregnancy, intrauterine and cervical pregnancy and intrauterine 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 algoritms for the diagnosis of ectopic pregnancy described previously can not be reliably used in this situation. Visualization of the heart activity in both intrauterine and extrauterine gestations by ultrasound makes the diagnosis certain. Although spontaneous heterotopıc pregnancy is a rare situation, we could see it in our case.

In the management of a heterotopic pregnancy, a conservative approach is generally prefered to preserve the intrauterine gestation[4]. In case of rupture and haemoperitoneum, surgical therapy is imperative, as in our case[15]. The standart treatment for ectopic pregnancy is surgery by laparoscopy or laparotomy. In our case, we prefered 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[16]. Methotrexate, RU486 or prostaglandins should not be used due to their potential adverse effects on the intrauterine gestation[17].

In conclusion, spontaneus heterotopic pregnancy is a very rare but life-threatening condition that 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.

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