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A Case of Heterotopic Pregnancy- Right Cornual Ruptured Ectopic with Non Viable Intrauterine Pregnancy

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Introduction

Ectopic pregnancy is one in which the fertilized ovum is implanted and develops outside the normal endometrial cavity. When an intrauterine pregnancy is co-existent with tubal or rarely with cervical or ovarian pregnancy it is called as heterotopic pregnancy. The incidence of heterotopic pregnancy is about 1 in 8000 pregnancies.

The diagnosis is establised by the characteristic history, presenting complaints of patient, examination findings and it is confirmed by ultrasonography and TVS.

Recognition of high risk cases, early diagnosis(even before rupture) with use of TVS, serum beta-hCG and laparoscopy have significantly improved the management of ectopic pregnancy.

Aim

To present a case of heterotopic pregnancy with right cornual ruptured ectopic

Setting- Department of Obstetrics and Gynaecology, Katihar Medical College, Katihar

Case Summary

A 30 year old G5P3+1L3 with 2 months amenorrhea presented in obstetric casualty with chief complaint of acute pain abdomen since 4 days. Pain was all over abdomen with no aggravating or relieving factors. There was history of nausea, vomiting since 2 days. Bladder and bowel were regular. Patient also had history of single episode of syncopal attack 1 day back lasting for 1-2 minutes. She also had complained of spotting per vaginum since 4 days. Her previous menstrual cycle was normal. There was no significant past, personal or any surgical history.

On Examination

BP- 150/90 mmHg
PR- 130/min
Afebrile, temp 98 F
Pallor + + +
No icterus, cyanosis, clubbing, lymphadenopathy, edema
Per abdomen: distention+, tenderness ++
P/S- spotting +
P/V-uterus-anteverted, bulky, right fornix full left fornix free, cervical motion tenderness+

Immediately preliminary investigations and ultrasonography done

Investigation

Hb- 5.2 gm%
ABORh- B positive
HIV– Non reactive
HBsAg– Non reactive
AntiHCV – Non reactive
Platelet count- 91000 /cmm
RBS – 75 mg/dl
Sr. Urea- 24 mg/dl
Sr. Creatinine- 0.7 mg/dl
Sr. Bili- 1.0mg/dl
SGOT- 28 IU/L
SGPT- 39 IU/L
ALP- 141IU/L
TLC- 6600 cu/mm
USG- Bulky uterus showing non viable embryo. Bulky right ovary with heterogenous echotexture. Mild collection in all peritoneal recess

Operative Procedure

After all preliminary investigations, patient was taken up for emergency laprotomy in view of heterotopic pregnancy with ruptured ectopic pregnancy.

Abdominal cavity was filled with blood. Blood was suctioned out. The rupture site was identified as right cornua. Abdominal hysterectomy was done

Other side ovary and fallopian tube were found normal. Hemostasis was secured and abdomen was closed in layers. Specimen was sent for histo-pathological examination.

Post Operative Period

She was given injectable antibiotics and blood transfusion.

Post operative period was uneventful and patient was discharged on 8th postoperative day and to be followed on OPD basis.

Discussion

Earlier patient presentation and more precise diagnostic technology typically allow identification before rupture. In these cases symptoms and signs of ectopic pregnancy are often subtle or even absent. In later diagnosis the classic triad of delayed menstruation, pain, vaginal bleeding or spotting may be present. In rupture lower abdominal and pelvic pain is usually severe. Abdominal palpation elicits dissention and tenderness.

Conclusion

After thorough review of history, examination and investigation exploratory laparotomy was done and since the site of ruptured ectopic was identified to be in the right cornua with a non viable intrauterine pregnancy a quick subtotal hysterectomy was done. With proper post operative care and blood transfusion patient was discharged on 8th post operative day.

So, timely intervention can significantly decrease, morbidity and mortality in cases of ruptured ectopic.

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