

Cases Report



Heterotopic Ectopic Pregnancy: A Challenging Diagnosis.

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Abstract:

Heterotopic pregnancy is defined by the association of an active intrauterine pregnancy and an ectopic pregnancy in the same patient. It is mostly found within patients whose ovulation was induced. The occurrence of heterotopic with in a spontaneous pregnancy remains rare, varying between 1 / 30,000 to 2 / 10,000 pregnancy. It presents a diagnostic challenge, because unrecognized it can jeopardize the patient's vital prognosis.

We report a case of heterotopic ectopic pregnancy diagnosed during surgery

Introduction

Heterotopic pregnancy is defined by the association of an intrauterine pregnancy and an ectopic pregnancy regardless of the location. The first case was discovered on an autopsy by Duvernet in 1708 [1]. It is a rare entity and is often difficult to diagnose. Indeed, the presence of an active intrauterine pregnancy limits the possibility of having recourse to additional examinations.

Through a case of heterotopic ectopic pregnancy, we describe the diagnostic and management modalities of this pathology.

Cases report:

This was a 28-year-old patient with a 1-year-old child and pregnant at 8 weeks of amenorrhea. The

ongoing pregnancy was a normal pregnancy, that is to say not induced. This patient was referred to us by her gynecologist in front of pain in the left iliac fossa evolving for 8 hours with an active intrauterine pregnancy on obstetric ultrasound. The examination found a pale but conscious patient. Pulse was 130BPM and blood pressure was 92 / 35 mmHg. We also found a left iliac fossa guarding with declining dullness. The results of laboratory tests revealed a positive BHCg, an hemoglobin level at 7.8.g / dl, platelets at 265,000 cells / ml and white blood cells 23,000 cells / ml. An ultrasound imaging was performed urgently and concluded to an active intrauterine pregnancy with a large intraperitoneal effusion suggesting a hemoperitoneum (figure 1).



Figure 1: active intrauterine pregnancy (green arrow).

Faced with the signs of hypovolemic shock refractory to filling and resuscitation, we decided to perform an exploratory laparotomy.

Intraoperatively, it was a two-liter hemoperitoneum related to a ruptured left isthmic ectopic pregnancy (figure 2).

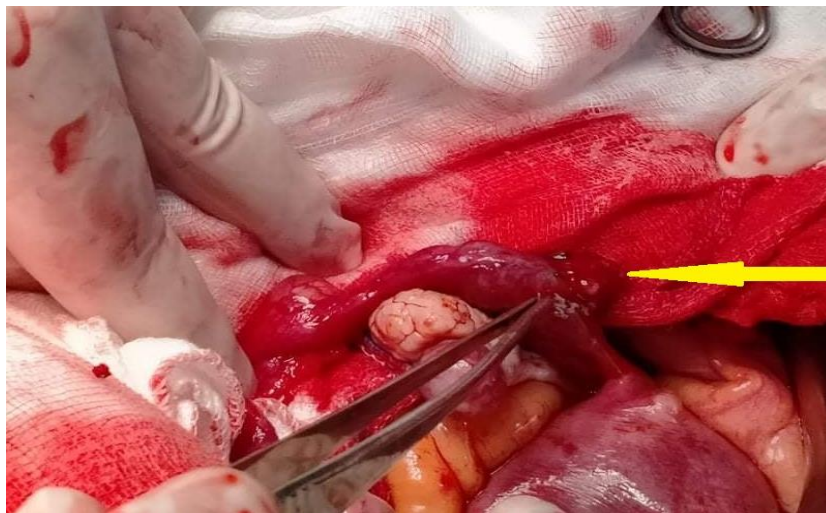


Figure 2 : ruptured ectopic pregnancy (yellow arrow).

We performed a left salpingectomy with simple outcomes. The patient was transferred to gynecology department the next day. The active pregnancy was kept and normally evolved.

Discussion:

First reported by Duvernet in 1708, heterotopic pregnancy is defined by the coexistence in the same patient of two pregnancies: one intrauterine and the other ectopic [1]. This pathology is due to the simultaneous fertilization of two eggs produced in the same cycle but which have different migration speeds, or to the fertilization of two eggs produced at short intervals during the same cycle by two spermatozoa from two different coitus [2].

The advent of medically assisted procreation and

tubal surgery are responsible for an increase in the frequency of this pathology [2]. In fact, the incidence is estimated at 1/30000 and may drop to 0.8% in the case of medically assisted procreation [3]. The other risk factors for this pathology are the same as ectopic pregnancy, in particular genital upper chlamydial infection [4]. Thus, the discovery of an intrauterine pregnancy progressing over a natural cycle should not rule out the diagnosis face of symptoms suggestive of an ectopic pregnancy.

The clinical presentation may be that of an ectopic pregnancy with the classic triad of amenorrhea, metrorrhagia and pelvic pain [2], but it is often misleading when the signs of intrauterine pregnancy are in the 1st place. Hence the symptomatology can be linked to a threatened

abortion and the diagnosis is made only at the stage of rupture of the ectopic pregnancy, with hemorrhagic shock in 13 to 45% of cases [5,6].

Ultrasound imaging is the key to diagnosis. It makes it possible to highlight the intrauterine pregnancy associated with an ectopic pregnancy and to diagnose a possible complication such as rupture [7,8].

The treatment is to treat the ectopic pregnancy while preserving the intrauterine pregnancy if the latter is still active [2]. Within stable patients, surgical management by laparoscopic route is the standard. In hemorrhagic shock, laparotomy is indicated [5]. Also, the surgical approach does not seem to affect the development of the pregnancy if the manipulation of the uterus and gestational corpus luteum were limited with an active pregnancy preservation rate from 30 to 75% [2,9,10]. If an intrauterine pregnancy has stopped and there is no sign of a complication, medical treatment with metotrexate can be considered while respecting the contraindications [11].

Conclusion:

Although still rare, heterotopic pregnancy is a condition that can be life-threatening to the mother. Faced with abdominal pain in the 1st trimester, the discovery of an intrauterine active pregnancy over a natural cycle should not rule out the diagnosis. Ultrasound imaging remains the key to the diagnosis and laparoscopy can be used to confirm the diagnosis and treat the ectopic pregnancy.

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