

Mysterious Pregnancy: A Diagnostic Dilemma

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Abstract

We present an interesting case in early pregnancy who reported to us with pain abdomen. Initial management was based on the clinical picture, serum beta hCG, and ultrasound findings. Few days later as there was a disparity between the three, surgical intervention was carried out. Despite all interventions we could not find the origin of high beta hCG levels in our case in the absence of a proven pregnancy. Even after an extensive literature search we were unable to dissolve the mystery of our case.

CASE REPORT

A 28 year old lady at six weeks of amenorrhoea and positive urine pregnancy test was referred to our early pregnancy unit with lower abdominal pain. This was a spontaneous first pregnancy. She had no history of per vaginal bleeding, discharge, gastrointestinal or urinary symptoms. There was no history of pelvic inflammatory disease and she had never used an intrauterine contraceptive device. Her past medical and surgical history was not significant. Clinical observations were stable. Examination revealed left lower abdominal tenderness with mild cervical excitation. Routine bloods were normal and serum beta HCG was 16,600 IU. An ultrasound was requested to confirm an intrauterine viable pregnancy. Ultrasound showed an intrauterine sac with a small yolk sac and a heterogeneous left adnexal mass of 6x6 cm. The probable differential diagnoses put forward were a hemorrhagic corpus luteal cyst and heterotrophic pregnancy. Considering the rarity of a heterotrophic pregnancy in this case and serum beta HCG being consistent with 6 weeks of pregnancy she was managed conservatively. Her serum beta HCG levels were sequentially monitored to rule out exponential rise. Ten days later a repeat scan performed showed the same size of intra uterine sac and yolk sac with slight increase in adnexal mass with 100ml of free fluid in pouch of Douglas. Her beta HCG levels were above 100,000 IU/ml. Though clinically she was stable, with such high serum beta HCG levels and an adnexal mass an operative laparoscopy and suction curettage were carried out after informed consent.

Intra operatively both tubes were apparently normal looking, left ovary had a cyst of 8x8 cms septate with clear fluid. Pouch of Douglas had clear straw coloured fluid. Uterine

curettings were suspicious of molar tissue. Histology of the cyst showed only fibrous component in a luteinised cyst with no evidence of dysplasia or malignancy.

The uterine curettings showed decidualised endometrium with focal Arias Stella reaction, with no evidence of chorionic or fetal tissue and could not confirm an intrauterine pregnancy. Post operative recovery was uneventful. Beta HCG levels began to fall and reached normal levels in four weeks time at which she had a normal period.

DISCUSSION

The advent of ultrasonography and biochemical investigations has brought major changes in clinical decision making. Sequential serum beta HCG and ultrasound help in minimising surgical interventions in modern practise. But in our case the presence of an adnexal mass with non progressive intrauterine findings and rising beta HCG levels warranted a surgical intervention. Interestingly we could not find the source of chorionic activity in our case. Literature search was carried out for raised beta HCG levels in the absence of intra uterine pregnancy, ectopic or trophoblastic tissue. Germ cell tuours, bladder malignancy, pituitary HCG and phantom HCG, are other possibilities for raised values but the beta HCG levels in these cases are mildly elevated and usually below 500 IU_{1, 2,3}.

Our case still remains a mystery with regards to the origin of such high beta HCG levels and absence of chorionic tissue.

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