

Heterotopic Pregnancy With A Live Female Infant: A Case Report

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Abstract

A 38-year-old G2P1⁺⁰, 1 alive, presented with sub acute ectopic pregnancy and had right salpingectomy for a ruptured tubal pregnancy involving the ampullary portion of the right fallopian tube. Post-operative follow-up revealed continuing symptoms of pregnancy and increasing uterine size. A diagnosis of singleton intra-uterine pregnancy was confirmed by abdominal ultrasonography a month later. The patient was managed to term and had normal delivery of a female infant

INTRODUCTION

Naturally occurring heterotopic pregnancy, first described by Duverney in 1708 at autopsy but now more commonly diagnosed in life, is rare.¹ With the rising incidence of ectopic pregnancies due to increasing risk factors and the rising incidence of multiple pregnancies due to expansion in assisted reproductive technologies in infertile couples, the chances of heterotopic pregnancies are increasing in many centres.

CASE REPORT

38 year old G2P1⁺⁰, 1 alive woman, presented on 13th of June, 2004 with 8 weeks of amenorrhea and acute abdominal pain associated with dizzy spells of 24 hours duration.

On examination at presentation, she was found to be pale, restless with tenderness over the suprapubic region. Blood pressure was 80/40mmHg with tachycardia (Pulse rate 120 /min). There was associated suprapubic tenderness. Vaginal examination revealed no abnormality. Lower abdominal paracentesis however yielded a free flowing non-clotting blood.

A diagnosis of ruptured ectopic pregnancy was made and resuscitation was commenced immediately with intravenous blood and oxygen administered by face mask.

Packed cell volume was 19%. Exploratory laparotomy was done and revealed ruptured ectopic ampullary pregnancy in the right fallopian tube. She had total right salpingectomy and was transfused appropriately. Her postoperative recovery was satisfactory and was discharged home.

She re-presented 5 weeks after the surgery on account of enlarging abdomen. Ultrasonography was done and it revealed an intra-uterine gestation compatible with 12 weeks cyesis. Routine antenatal care was commenced with no complications detected. On 18th of January 2005, she had spontaneous vaginal delivery of a live female infant at gestational age of 39 weeks. Baby weighed 3.5 kilogrammes with Apgar's score of 8 in 1 minutes and 10 in 10 minutes. Mother and baby were discharged home 2nd day of delivery in good health.

DISCUSSION

Naturally occurring heterotopic pregnancy (co-existence of intrauterine pregnancy with ectopic pregnancy) remains rare. But in the last three decades, its incidence has been rising in step with the increasing risk factors for ectopic pregnancy and the increasing use of ovulation induction and new assisted reproductive techniques in infertile couples.²

This patient falls into the category of naturally occurring heterotopic (combined) pregnancies. Early diagnosis was not easy. The threat to life of a ruptured tubal pregnancy drew attention to the ectopic aspect of the condition.

Persistence of symptoms of pregnancy and abdominal ultrasonography revealed the intrauterine aspect of the condition. The patient's management to term and safe delivery of a female infant was uneventful. A good outcome as in this case is not always the rule. Approximately two thirds of intrauterine pregnancies in heterotopic pregnancies are delivered alive while one third are aborted.

This patient had two risk factors, which combined to produce this rare condition. She had a family history of twin pregnancies and had secondary infertility ten years before her pregnancy.

In conclusion, lessons from this case is the need for increased surveillance for the occurrence of heterotopic pregnancies in Africa for the following reasons:³

- (a) The incidence of pregnancies in our environment remains among the highest in the world
- (b) The higher incidence of multiple pregnancies in this environment than in most other regions. In Nigeria, there are 45 twin pairs per 1000 births. This contrasts with 10–12 pairs per 1000 births in Caucasians and 5 pairs per 1000 births in some Far East (Asian) countries
- (c) The high incidence of multiparity and grandmultiparity.
- (d) The increase in risk factors for ectopic pregnancy: pelvic inflammatory disease (PID), previous sexually transmitted infections, previous abdominal surgery, previous ectopic pregnancy, secondary infertility, intrauterine contraceptive

devices (IUCDs), progestin-only oral contraceptives, delayed marriages, and tubal surgery.

- (e) The introduction of ovulation-induced (fertility) drugs and new assisted reproductive techniques

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