



Case Report

Positive Outcome of Heterotopic Pregnancy Following Ovulation Induction: A Rare Case Report

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Abstract

We report a combined intra-uterine and ruptured tubal pregnancy following ovulation induction by clomiphene citrate (cc) and timed intercourse. The diagnosis of heterotopic pregnancy (HP) is the major problem until occurrence of tubal rupture. Because HP is a life threatening condition, the diagnosis should be made as soon as possible. In a spontaneous conception HP is a rare event. The risk of HP significantly increases after ovulation induction. Clomiphene itself should be associated with a high HP rare. We present a case with normally developing intra uterine singleton pregnancy successfully with synchronous tubal pregnancy following ovulation induction by cc.

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Introduction

Heterotopic pregnancy is a condition where simultaneous gestation occurs at two or more implantation sites. It was first reported in 1708 as an autopsy finding.¹ It is a rare entity. The estimated incidence of IHP accepted between 1:30,000 to 1:8000 pregnancies.² With assisted reproduction technique however the incidence increases to between 1:100 to 1:500.³ It is a potentially fatal condition. Delay in diagnosis the condition and failure to proceed quickly with the requisite anesthesia and surgery are dangerous for both the mother and the intrauterine pregnancy.⁴

Case report

Mrs Farhana Abedin a 32 yrs old, house wife para-0, gravida-2nd from middle class family attend authors private chamber on 10.04.2009 with the complaints of amenorrhoea about 8 weeks with slight lower abdominal pain and irregular scanty P/v bleeding for last 1 weeks. On routine USG it

was diagnosed as a case of 7 weeks viable intra uterine pregnancy and treated as a case of threatened abortion. Regarding her past obstetrics history she is married for 5 yrs and diagnosed as a case of PCOS and treated by many Gynaecologist. One year back she conceived after Ovulation induction but spontaneous abortion occurs at 3 months of pregnancy and D & C was done due to incomplete abortion. For the last 3 months she is taking ovulation inducing drug (cc). Now inspite of treatment of threatened abortion her symptoms not relieved and after 1 month on 11.05.2008 she again attend to me with the complaints of sudden sever lower abdominal pain for 1 day with irregular P/v bleeding. Then an urgent USG of lower abdomen done which reveals 10 weeks viable intra uterine pregnancy with left sided tubo-ovarian mass (size about 8.1 cm x 6.7 cm), mild to moderate fluid collection in peritoneal cavity and then decision was taken for urgent laparotomy.

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After exploratory laparotomy it was found that uterus is gravid and peritoneal cavity is full of blood and active bleeding point from ampullary part of left fallopian tube present then decision was taken for left sided salpingectomy and abdomen was closed in layers after achieving proper haemostasis, toileting & giving a drain tube with minimum handling to gravid uterus. Her postoperative period was uneventful. Tissue from the growth/ruptured site sent for histopathological examination. Histopathology report confirm diagnosis of ruptured tubal ectopic pregnancy. Patient was discharged on 5th POD without any complication. Then patient was on regular follow up. Rest of the period of her pregnancy was uneventful with good fetal growth. At 32 weeks of gestation she developed GDM and treated with inj. Insulin her EDD was on 3.12.08. So decision was taken for LUCS on 15.11.2008 at her completion of 38 weeks of pregnancy. Patient delivered a healthy female baby weight 3 kg. A/S-⁸/₁₀ (5 min). Then patient was discharged on 5th post operative day without any complication and healthy baby.

Discussion

The coexistence of intra uterine and extrauterine pregnancy also known as heterotopic pregnancy (HP) was previously a rare phenomenon. Due to wide spread use of ovulation induction therapy and other assisted reproductive technique incidence has now been thought to be more frequent and has recently reported to be as high as 75 to 13% or even higher if there has been preexisting tubal damage. HP is difficult to diagnose and is a potentially dangerous condition for both mother and intrauterine pregnancy. It is not surprising that most HP are only diagnosed following rupture and haemorrhagic shock. The management of HP a conservative approach is generally preferred to preserve the intra-uterine pregnancy. In case of rupture and haemoperitonium surgery is imperative. During surgery special care should be taken not to disturb

uterus. The most common surgical technique is partial salpingectomy after laparotomy. Laparoscopic surgery is another option for haemodynamically stable patient. In HP despite tubal rupture and haemorrhagic shock the prognosis for intra-uterine gestation is good and on going pregnancy rate of 75.6% were reported by Reece et al (5). In our case the pregnancy progressed normally and revealed normal fetal development by USG.

In conclusion where an ectopic gestation is suspected after ovulation induction by CC or ART the presence of intra-uterine pregnancy can no longer be considered reassuring and a HP has to be ruled out because conservative management of HP will lead to a successful intra-uterine pregnancy outcome. Therefore conservative surgery should be treatment of choice for HP. This rare universality of the life threatening condition and treatment option resulting in a uncomplicated delivery of intra-uterine pregnancy.

References

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