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Case Report

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HETEROTOPIC GESTATION: ULTRASONOGRAPHIC DIAGNOSIS WITH ECTOPIC PREGNANCY NOT ROUTED IN THE EMERGENCY DEPARTMENT - CASE REPORT

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Abstract

Heterotopic pregnancy is a rare entity, characterized by a topical pregnancy associated with an ectopic pregnancy, especially when it occurs spontaneously. The risk factors are similar to those seen in ectopic, with the highest incidence in women who undergo assisted reproduction techniques. The diagnosis is made with positive β-HCG and ultrasonographic examination, usually after an acute hemorrhagic abdomen due to the rupture of the ectopic pregnancy, with treatment differing in relation to the patient's clinical condition and the gestational age.

Key Words: heterotopicpregnancy, ectopicpregnancy, ultrasonography

INTRODUCTION

Heterotopic pregnancy is a rare entity, characterized by a topical, intrauterine pregnancy, associated with an ectopic, extrauterine pregnancy, especially when it occurs spontaneously (1). The reported incidence ranges from 0.6 to 2.5 cases per 10.00 gestations, and is slightly higher in women who undergo assisted reproduction techniques. It is usually diagnosed after acute hemorrhagic abdomen resulting from the rupture of ectopic pregnancy, performed by ultrasonographic study (2).

We report a case of heterotopic pregnancy, diagnosed in an emergency department, with a non-rotated ectopic pregnancy and with a topical pregnancy with favorable evolution until full term delivery.

CASE REPORT

Patient, P. 19, G1P0A0, with a five-week menstrual delay, without previous obstetrical ultrasonography, was admitted to the service with diffuse abdominal pain and vaginal bleeding. Beta - HCG dosing was performed, with a positive result.

On transvaginal ultrasonography, heterogeneous expansive formation was evidenced in the left tubal topography without flow to color Doppler, concomitant with topical gestation with live embryo, without signs of free fluid in the pelvic cavity. Magnetic resonance imaging revealed heterogeneous nodular formation located in the left adnexa region, with some internal cystic focal points along associated with gravid uterus containing live embryo.

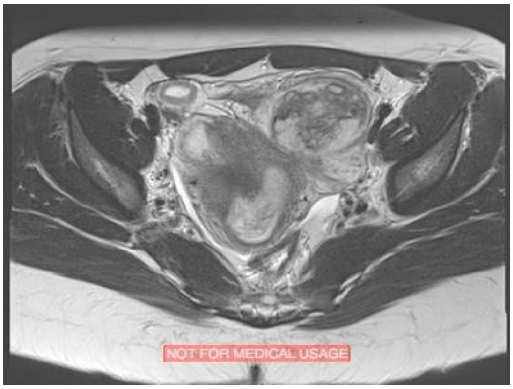

Figure 1: Magnetic ressonance imaging in axial section and T2-weighting, without fat saturation, showing enlarged gravid uterus, associated with mass, heterogeneous in the left adnexal region. Patient remained stable, performing sequential ultrasound for follow-up, showing stability of characteristics and size of the adnexal mass, with normal development of the intrauterine fetus, with consequent term child-birth, by cesarean section.

DISCUSSION

Heterotopic gestation is a rare condition in which there is ectopic gestation simultaneously with intrauterine gestation, and in the first case the most frequent location is the uterine tube, which may also be cornual, cervical, ovarian, abdominal and cesarean scar (1,2). The incidence varies from 1: 30,000, but after assisted reproduction the frequency of this complication was 1: 100-500 gestations (2).

The risk factors associated with heterotopic gestation are the same as those related to ectopic pregnancy, represented mainly by mechanical disorders and / or functional factors that prevent or delay the passage of the embryo into the uterine cavit (3).

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Among them, pelvic inflammatory disease, uterine malformation, advanced age, smoking, previous pelvic surgery, history of infertility and the application of assisted reproduction techniques are mentioned (3).

The clinical manifestations are varied, being the first complaints those related to acute hemorrhagic abdomen (abdominal pain and signs of hypovolemic shock). Heterotopic gestation may be suspected when there is painful abdomen to palpation along with signs of peritoneal irritation, adnexal mass, and enlarged uterus (4). In 70% of the cases, the diagnosis occurs at 5-8 weeks of gestation and early diagnosis is difficult, occurring mostly after tubal rupture. Biochemical markers, beta-HCG, do not guide propedeutics, since they are at normal levels, secondary to the normal hormonal activity of trophoblastic tissue (5).

Regarding treatment, there is no consensus on the best course of action to be followed, relating to the site of implantation of the ectopic gestational sac and the time of diagnosis. The laparotomic or laparoscopic surgical approach is the choice when the ectopic is tubal, as in the case of the patient in question (6).

CONCLUSION

There are few reports of heterotopic gestation and the present work, in its limited coverage in the literature, contributes to the knowledge about the subject.

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