İst Tıp Fak Derg 2014; 77:3 **CASE REPORT/ OLGU SUNUMU**
J Ist Faculty Med 2014; 77:3
http://dergipark.ulakbim.gov.tr/iuitfd
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HETEROTOPIC PREGNANCY MISDIAGNOSED AS ACUTE APPENDICITIS

AKUT APANDİSİT ÖN TANISIYLA GÖZDEN KAÇIRILMIŞ HETEROTOPİK GEBELİK- OLGU SUNUMU

Gülçin ŞAHİN ERSOY*, Meryem EKEN**

ABSTRACT
The diagnosis of heterotopic pregnancy is usually more difficult than the other obstetric emergencies, necessitating a thorough anamnesis and a high diagnostic suspicion, followed by the utilization of ultrasonography as the most valuable diagnostic tool.
In this report the intraoperative finding of a heterotopic pregnancy in an adult female patient was presented while being operated by the general surgeon with the working diagnosis of acute appendicitis under emergency conditions.
Key words: heterotopic pregnancy; appendicitis

ÖZET
Heterotopik gebeliğin tanısı diğer obstetrik acillere kıyasla daha zordur, anamnezin detaylı olarak alınmasını ve yüksek düzeyde klinik şüphelenmeyi gerektirir. Tanıda en değerli yöntem ise ultrasonografidir.
Bu yazıda akut batın sebebiyle akut apandisit ön tanısı konulup genel cerrahi kliniği tarafından opere edilen ve operasyon sırasında istenen konsültasyon sonunda heterotopik gebelik tanısı konulan bir olgu sunulmaktadır.
Anahtar Sözcükler: Heterotopik gebelik; apandisit

INTRODUCTION

A heterotopic pregnancy is a rare complication of pregnancy in which both extra-uterine (ectopic) and intrauterine pregnancy occur simultaneously. As a result of this coexistence in the early gestational period the diagnosis of heterotopic pregnancy is usually more difficult than the ectopic pregnancy. Spontaneous heterotopic pregnancy is a rare event and the incidence is 1: 30,000 pregnancies (8). As more and more infertile couples turn to assisted reproductive technique, the incidence of heterotopic pregnancy has expectedly increased from 1.9% to 2.9% (5). In this report the intraoperative finding of a spontaneous heterotopic pregnancy in an adult female patient was presented while being operated by the general surgeon with the working diagnosis of acute appendicitis under emergeny conditions.

CASE REPORT

A twenty-year-old female patient was admitted to the emergency department of this hospital with a lower abdominal pain of sudden onset. Her history revealed a single live birth with casaerian section approximately 10 months ago. She had tenderness at her right lower abdominal quadrant with defence and rebound; her complete blood count revealed leukocytosis above $16x10^9$/L. Without ultrasound examination or obstetric consultation she was taken to the operation room for exploratory laparotomy with the working diagnosis of acute appendicitis. Peroperatively a hemorrhagic lesion was noticed on her right adnexial region and a consultation was requested from the Obstetrics and Gynecology department. Our intraoperative examination revealed a soft and bulky uterus matching the size of 12 weeks gestational age in addition to a hemorrhagic lesion approximately 3 cm in diameter in

Date received/Dergiye geldiği tarih: 06.11.2014 - Dergiye kabul edildiği tarih: 21.11.2014
* Kartal Dr. Lütfi Kırdar Research and Training Hospital, Istanbul, Turkey
** Zeynep Kamil Research and Training Hospital, Istanbul, Turkey
(İletişim kurulacak yazar: meryemkurek@yahoo.com)

the right adnexial area comprising the ampullary and infundibular region, a finding consistent with tubal ectopic pregnancy. Appendectomy and right salpingectomy were performed but dilatation and curettage was omitted due to the suspicion of a coexisting intrauterine pregnancy and minimal manipulation was exerted on the uterus to prevent the initiation of uterine contractions.

Postoperatively the ultrasonographic investigation of the patient revealed a live intrauterine fetus with 12 weeks of gestational age. The pathological analysis of the hemorrhagic specimen resulted as tubal ectopic pregnancy thus the diagnosis of heterotopic pregnancy was confirmed.

In the postoperative period intramuscular hydroxyprogesterone 500 mg weekly and oral progesterone 200 mg three times daily were administered for two weeks. Thereafter the patient was kept in close follow-up and the pregnancy was carried to term. She had a cesarean section at 39 weeks of gestation and gave birth to a live male baby with apgar scores of eight and ten at the first and fifth minutes respectively.

DISCUSSION

Due to the incremental demand on the assisted reproductive techniques in the recent years the incidence of heterotopic pregnancy is on a steady rise. The main risk factors for the development of heterotopic pregnancy do not differ from those for the ectopic pregnancy and include history of pelvic surgery, sexually transmitted diseases, pelvic inflammatory disease, previous occurence of ectopic pregnancy and assisted reproductive techniques (1). In a systematic review by Talbot et al. in 2011, 71% of cases had only one risk factor and 10% had three or more risk factors (4). In the same review 29% of cases were found to have no risk factors at all. The patient presented in this case report also did not have any risk factors for the occurence of heterotopic pregnancy. The diagnosis in such cases is extremely difficult, necessitating a thorough anamnesis and a high diagnostic suspicion, followed by the utilization of high-resolution transvaginal ultrasonography as the most valuable tool for the diagnosis of heterotopic pregnancy (2).

Presumably another obstacle interfering with the diagnosis of heterotopic pregnancy in the presented case was the history of a recent delivery about 10 months ago. The patient had been still breastfeeding her baby and according to the patient's statement her menstrual periods have not yet returned. In light of this misguiding detail in the anamnesis the general surgeon did not suspect the presence of a pregnancy and did not order β–HCG analysis or ultrasonographic examination before the explorative laparotomy.

The management of heterotopic pregnancy varies for different individual cases. Expectant management can be preferred in selected asymptomatic cases with limited craniocaudal length and lack of fetal cardiac activity. In the presence of unwanted intrauterine pregnancy methotrexate or mifepristone (RU486) can be used to terminate pregnancy but surgery remains as the most frequently preferred treatment method.

Although some authors have reported that laparotomy does not seem to interrupt intrauterine pregnancy (3), others have reported a 40% loss of viable fetuses (7). Several others have mentioned the value and safety of laparoscopy in the diagnosis and treatment of heterotopic pregnancy (6, 2). In order to offer the laparoscopic intervention as an alternative choice and to increase the chance of the viability of the intrauterine fetus, heterotopic pregnancy should be included in the differential diagnosis of acute abdomen among fertile women who are about to undergo an emergent explorative laparotomy.

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