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## **Heterotopic Pregnancy with Live Twins**

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### **ABSTRACT**

A 24-year-old primigravida presented with subacute ectopic pregnancy and had salpingectomy for a ruptured tubal pregnancy involving the ampullary portion of the left fallopian tube. Post-operative follow-up revealed continuing symptoms of pregnancy and increasing uterine size. A diagnosis of multiple pregnancy was confirmed by abdominal ultrasonography. The patient was managed to term and had normal delivery of twins. (*Afr J Reprod Health* 2002; 6[3]: 117–119)

### **RÉSUMÉ**

**Grossesse hétérope aux jumeaux vivants.** Une primigeste âgée de 24 ans a présenté une grossesse ectopique sous-aiguë et elle a eu une salpingectomie pour une rupture de grossesse tubaire concernant la portion ampullaire

de la trompe utérine gauche. Les suites opératoires ont révélé des symptômes ininterrompus de la grossesse et l'accroissement de l'utérine. L'ultrasonographie abdominale a confirmé le diagnostic d'une grossesse multiple. La patiente a suivi du traitement jusqu'à terme et elle a eu un accouchement normal des jumeaux. (*Rev Afr Santé Reprod* 2002; 6[3]: 117–119)

**KEY WORDS:** *Heterotopic pregnancy, ectopic pregnancy, salpingectomy, twins*

## INTRODUCTION

Naturally occurring heterotopic pregnancy, first described by Duverney in 1708 at autopsy but now more commonly diagnosed in life, is rare.<sup>1</sup> 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

A 24-year-old primigravida was admitted on January 4, 1998, presenting with a history of two episodes of vaginal spotting following eight weeks amenorrhea. Her LMP was November 5, 1997. The first episode of spotting was on December 29, 1997, and it lasted for one day. The second episode started on January 3, 1998, and was continuing. She also complained of weakness and lower abdominal pain. She gave a past history of appendectomy in 1991. On examination, she was pale with a rapid pulse and had abdominal tenderness. A diagnosis of subacute ectopic pregnancy was made and the patient was prepared for surgery.

On January 5, 1998, laparotomy revealed a ruptured tubal pregnancy involving the ampullary portion of the left fallopian tube, massive hemoperitoneum and a bulky uterus about 10 weeks with a tiny fibroid posteriorly. The right fallopian tube and both ovaries were normal. Left salpingectomy was performed. Blood loss was 1250 ml. The patient made an uneventful recovery and was discharged home on the 7th post-operative day.

- *The histology report showed retained products of conception.*

The patient was readmitted on February 5, 1998, with a history of nausea, vomiting, abdominal discomfort, fever and weakness. She gave a history of laparotomy one month earlier and her LMP as November 5, 1997. On examination, she was afebrile but slightly pale. Temperature 37°C, pulse 90, respiration 30, blood pressure

110/60mmHg. Abdominal examination showed a fundal height of 16 weeks (gestational age 13 weeks).

Abdominal ultrasonography revealed intrauterine gestation – twins. Her EDD calculation was August 12, 1998.

- *Laboratory results:* Haemoglobin 9.8 g/dl. Urine: Glucose nil, protein +, blood +, pus cells +.

The patient was managed at the antenatal clinic and admitted when she went into established labour on August 2, 1998, at 7.30 a.m. Early labour was said to have started the previous night at about 8 p.m. On admission, her temperature was 36.6°C, pulse 80, respiration 24, blood pressure 110/60mmHg, fetal heart rates 140 and 148. Fundal height: term. Presentations: 1st baby cephalic, engaged; 2nd baby breech, membrane intact. No vaginal bleeding. Vaginal examination: cervix 90% effaced, Os 4cm dilated, station 0. Assistance given: enema, artificial rupture of membrane (ARM), 5% dextrose intravenous drip. First twin: female, delivered at 6.45 p.m., vacuum extraction due to poor maternal effort, Apgar 7/1, 9/5, head circumference 34cm, length 50cm, weight 3.7kg. Second twin: male, delivered at 6.50 p.m., breech extraction, apgar 6/1, 8/5, head circumference 36cm, length 50cm, weight 3.8kg. Both babies developed physiological jaundice between the second and third days. Both responded well to phototherapy and phenobarbitone. First twin: female, total bilirubin 5.7mg/dl, conjugated bilirubin 0.1mg/dl. Second twin: male, total bilirubin 4.6mg/dl, conjugated bilirubin 0.08mg/dl.

Mother and babies were discharged home on August 18, 1998. Follow-up: photograph of the twins; code-named by parents, Testimony (the girl) and Miracle (the boy), at the age of nine months. Their mother is now 15 weeks pregnant (April 4, 2000).

## 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.<sup>2</sup>

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 dizygous twins (female and male) were uneventful. A perfect 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 had appendectomy seven years before her pregnancy. The possibility of post-appendectomy adhesions rendered her prone to ectopic pregnancy.

The lesson from this case is the need for increased surveillance for the occurrence of heterotopic pregnancies in Africa for the following reasons:

- (a) The incidence of pregnancies here remains among the highest in the world.
- (b) The higher incidence of multiple pregnancies here 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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