International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Mandrupkar TC et al. Int J Reprod Contracept Obstet Gynecol. 2024 Nov;13(11):3359-3361
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20243206

Case Report

A rare case report on molar heterotopic pregnancy

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Received: 20 April 2024
Revised: 07 October 2024
Accepted: 08 October 2024

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ABSTRACT

A 34 y/o G4P3L3, with 1.5 months of amenorrhoeas, presented with complaints of pain in abdomen and vaginal spotting. Patient was diagnosed as a case of heterotopic pregnancy with ruptured ectopic on USG. The patient had her left oviduct removed by means of exploratory laparotomy, followed by dilatation and evacuation of retained products of conception in the uterus. The presented case highlights the importance of meticulously performed ultrasound examination. Also, the visualization of a normal intrauterine pregnancy in the ultrasound examination does not exempt the examiner from a need of distinct imaging of the adnexa. The case also conveys the importance of histological examination of products of conception which helps to confirm an appropriate diagnosis, thereby the obstetrician can offer appropriate treatment, counselling and follow up to the patient. Early diagnosis of this pathology decreases the risk of complication incidence as well as maternal mortality.

Keywords: Molar, Heterotopic, Amenorrhoeas

INTRODUCTION

Heterotopic pregnancy is the coexistence of intrauterine pregnancy and extrauterine pregnancy, single or multiple, located in the fallopian tube, ovary, cornua of uterus, cervix or peritoneal cavity.[1-3] With the presence of hydatidiform mole it is even rarer. Due to recent advances in assisted reproductive techniques, the incidence of heterotopic pregnancies increased. We report an unusual case of heterotopic pregnancy with intrauterine molar pregnancy and left tubal ectopic pregnancy.

CASE REPORT

A 34 years old female with obstetric score of G4P3L3 with all vaginal deliveries, with amenorrhoea of 1.5 months, came to emergency ward with complaints of pain in abdomen for 3 days and history of per vaginum spotting 3 days ago. There were no complaints of nausea or vomiting or febrile illness.

Past obstetric history was normal. Urine pregnancy test was done and was positive. Clinical examination revealed soft abdomen with mild tenderness in left iliac fossa region. Per vaginal examination revealed bulky uterus with left cervical tenderness. There was no evidence of mass lesion.

Transvaginal ultrasonography of the pelvis showed gestational sac in left adnexa with single foetal pole with cardiac activity, CRL of 1.2 cm corresponding to 7 weeks 3 days. There was also evidence of bulky uterus with single irregular intrauterine gestational sac, with hyperechoic foetal pole with no cardiac activity with CRL of 1 cm corresponding to 7 weeks 1 day, suggestive of failed intrauterine pregnancy. Moderate echogenic free fluid was present in pouch of Douglas suggestive of hemoperitoneum.

Routine haematological investigations were done and Haemoglobin was found to be 6.2, thus 2 pints of packed

cell volume were transfused. Biochemical investigations were within normal limits. β-hCG levels were done and were found to be 5124.

Figure 1: Ultrasound examination showing presence of intrauterine and extrauterine pregnancy.

After taking high risk consent, exploratory laparotomy was performed. Intraoperatively, frank hemoperitoneum was noted along and around 600 gm of clots were removed. Left sided ruptured tubal mass of 3×2 cm was seen at the ampullary region. Left salpingectomy was done and specimen was sent for histopathological examination. Right sided fallopian tube and ovary were found normal. Laparotomy was followed by dilatation and evacuation and products of conception were sent for histopathological examination. Patient was then shifted to general ward and received post operative care.

Histological examination of the specimen sent from the tube revealed ruptured tube with trophoblastic cells and occasional chorionic villous embedded in the wall of tube.

Specimen sent from endometrial cavity revealed hydropic and avascular chorionic villi with decidua and haemorrhage suggestive of partial hydatidiform mole.

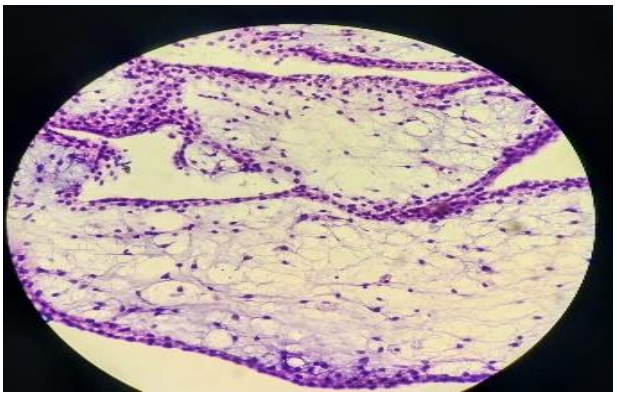

Figure 2: Histological examination of the removed fallopian tube showing presence of trophoblastic cells and occasional chorionic villous.

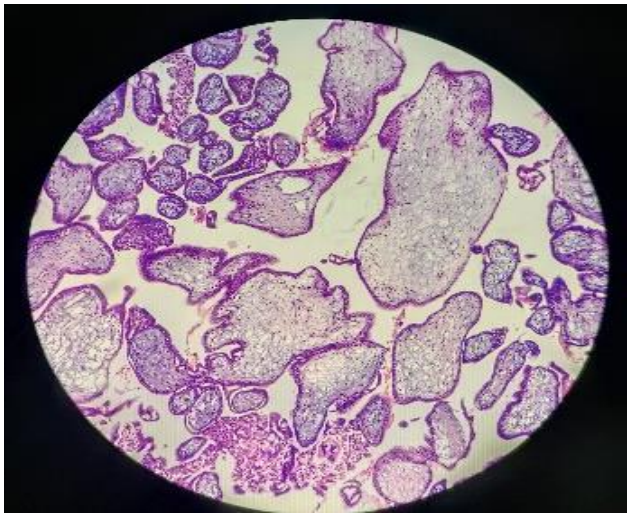

Figure 3: Histological examination of endometrial products of conception showing hydropic and avascular chorionic villi suggestive of hydatidiform mole.

Repeat BHCG levels were sent after a week and were found to be 977. Patient was asked to follow up with BHCG levels until three successive B-hCG levels were found to be negative.

DISCUSSION

Heterotopic pregnancy occurs quite rarely. Its incidence equals 1:30,000 of cases. [4] Risk factors of heterotopic pregnancy include assisted reproductive techniques: multiple embryo transfer and ovulation induction, use of an intrauterine contraceptive device, prior tubal surgery, history of pelvic inflammatory disease, history of a previous ectopic pregnancy. It can result in serious and possibly fatal complications, including intraabdominal bleeding, uterine rupture, abortions or preterm labour.[5,6] Management depends on weeks of gestation. Surgery still being the treatment of choice in most cases.

Hydatidiform moles arise due to abnormal fertilization of an empty ovum by a haploid spermatozoon, which later divides. Partial moles usually arise from dispermic fertilization of a haploid ovum, resulting in a triploid genome.[7] Risk factors include age-less than 20 years or more than 40 years, Asian ethnicity nutrition deficiencies including lack of folate, beta-carotene or protein, a previous molar pregnancy or other gestational trophoblastic disease. It might complicate into persistent trophoblastic disease, gestational trophoblastic neoplasia, heavy vaginal bleeding, hyperemesis gravidarum, hyperthyroidism, anaemia, preeclampsia. Histopathological examination of products of conception remains gold standard for diagnosis.[8] Appropriate monitoring of beta-hCG titres in this case is all the more important as it helps to diagnose persistent ectopic gestation and to rule out the presence of malignant trophoblastic disease.[9]

CONCLUSION

Concluding, the presented case is quite unnatural, thus its occurrence required to be reported. Visualization of a normal pregnancy in the ultrasound examination does not exempt the examiner from a need of precise imaging of the adnexa. The case also conveys the importance of histological examination of products of conception which helps the pathologist to provide an appropriate diagnosis, thereby the clinician can offer appropriate counselling and follow up to the patient. Early diagnosis of this pathology decreases the risk of complication incidence as well as women mortality.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Mandrupkar TC, Tambe SG, Padore IS. A rare case report on molar heterotopic pregnancy. Int J Reprod Contracept Obstet Gynecol 2024;13:3359-61.