Co-Existent Intrauterine and Ectopic Tubal Pregnancy

Colonel K D Printer MB FRCOG L/RAMC

Consultant Obstetrician and Gynaecologist

Princess Alexandra Hospital, Royal Air Force, Wroughton, Swindon

SUMMARY: A case of co-existent intrauterine and ectopic pregnancy is described in a patient from overseas. The difficulty in diagnosis and management is discussed, together with recent literature.

Case Report

The patient, aged 40 years, para 2 + 0, and on holiday in the UK from overseas, was admitted to hospital as an emergency with a history of acute lower abdominal pains of four days' duration. Her last menstrual period began nine weeks before the onset of pain.

An ectopic pregnancy was diagnosed clinically and at laparotomy a right tubal pregnancy found. Three pints of blood was noted in the abdomen. Right salpingectomy was done. The uterus was noted to be bulky, but no D & C was performed. She was discharged some eight days later and returned overseas. Histology subsequently confirmed the presence of a tubal pregnancy.

She visited her local GP overseas two months after her operation as she thought she was putting on weight. She had not had any vaginal bleeding since her right salpingectomy. She was given Tenuate Dospan. About a week later she revisited her GP complaining of lower abdominal pains and a slight brown vaginal discharge. On examination then to everyone's surprise she was found to be about 20 weeks pregnant! She had had intercourse for the first time since her operation three months postoperatively. In view of her age and circumstances, a request for consideration of termination of pregnancy was forwarded and the patient was transferred from overseas to the UK five weeks later.

On examination on arrival from overseas she was found to be 24 weeks pregnant. Termination at this stage was thought to be unwise. Adoption was suggested and the patient readily agreed to this and the pregnancy continued normally. Forty weeks after her last menstrual period, or thirty weeks after her operation she had a normal vaginal delivery of a live healthy male infant, weighing 2.95 kg. The baby was adopted and she returned home following a Pomeroy's sterilization operation.

Discussion

The co-existence of ectopic and intrauterine pregnancy has been thought to be rare. For example, according to Beckmann, Tomasi & Thomason¹, the incidence of this has been reported as between one in 15,000 to one in 30,000 pregnancies. Hann, Bachmann and McArdle² reported the possibility of intrauterine fetus surviving as one in three to one in two cases. In this case twins were conceived, one in the tube and one in

utero. The ectopic tubal pregnancy was easily diagnosed and treated. The possibility of a co-existing intrauterine pregnancy was not entertained, even though there was no vaginal bleeding at the time of or after salpingectomy. It was a surprise when, following her return to her home abroad the patient was found to be 20 weeks pregnant. With hindsight, the size of the uterus was compatible with the period of amenorrhea. The ruptured ectopic occurred when she was about eight weeks pregnant.

Recent gynaecological literature indicates that this condition may be more common than originally thought. A re-appraisal of simultaneous intra- and extra-uterine pregnancy done by Richards, Stempel & Carlton³ showed an actual incidence of one in 2600 pregnancies. Cases reported from Beth Israel Hospital² show an incidence of one in 6778 pregnancies. This increased incidence is thought to be due to a number of factors including the increased incidence of ectopic pregnancy (0.5 to 1.1 of all pregnancies), the use of ovulation inducing drugs, the increased incidence of pelvic inflammatory diseases, the trend for delay in childbearing to the later reproductive years, and the higher incidence of endometriosis which can inhibit oviduct motility by peritubal endometrial deposits and adhesions⁴.

According to Hayes & Haley⁵ a high index of clinical suspicion is necessary to diagnose this condition. Patients with persistent adnexal pain after termination of intrauterine pregnancy or those who fail to shed decidua after surgery for an ectopic pregnancy, should be suspected of having a concurrent intra- and extra-uterine pregnancy. The modern ultrasound examination is a very potent tool in the diagnosis of this condition. It is important to remember that ultrasonic demonstration of an intrauterine gestational fetal sac does not necessarily preclude a simultaneous extrauterine pregnancy and vice versa.

It was not possible to establish by the methods recommended by Hayes & Haley⁵ whether this was a case of superfecundation, ie two separate pregnancies from two ovulations in the same cycle, or superfoetation, ie two separate pregnancies from two ovulations in separate menstrual cycles.

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ACADEMIC ACHIEVEMENTS

Fellowship of the Royal College of Physicians	Col D S Jolliffe, L/RAMC
Degree of Doctor of Medicine of the University of Newcastle-upon-Tyne	Lt Col R P Craig, RAMC
Final Fellowship in Otolaryngology at The Royal College of Surgeons of Edinburgh	Major J A J Deans, RAMC
Membership of the Faculty of Community Medicine-Pt II	Col C G Callow, RAMC
Diploma of Industrial Health	Major M G Braithwaite, RAMC
Associate in the Faculty of Occupational Medicine	Major M G Braithwaite, RAMC
Diploma of Tropical Medicine and Hygiene, Liverpool	Major J F Navein, RAMC
Diploma in Tropical Medicine and Hygiene, Liverpool	Captain R T A Walker, RAMC
Diploma of the Royal College of Obstetricians and Gynaecologists	Captain P A Johnson, RAMC
Diploma in Child Health	Captain C Grummitt, RAMC Major C Sidebotham, RAMC Major J F Navein, RAMC
DRCOG	Captain J Barrel, RAMC Captain A Rixom, RAMC Captain P Travis, RAMC
FFARCSI	Major I G Johnson, RAMC
FRCSI	Major J D C Bennett, RAMC
MRCGP	Captain G M Allan, RAMC Major G J Hayes, RAMC Capt C A J Hodson, RAMC Major K D Jones, RAMC Captain J W McCorkindale, RAMC Captain J J McPeake, RAMC Major M A Staunton, RAMC