



Rare Presentation Heterogeneous Pregnancies

Article History

Received: 21.02.2021
Revision: 07.03.2021
Accepted: 17.03.2021
Published: 20.03.2021
Plagiarism check - Plagscan

Author Details

Imad Abedzaid Mohan Aljanabi¹, Nada Kadum Kareem¹ and Marwa Habeeb Nazal²

Authors Affiliations

¹Ministry of Health, Department of Health Babylon, Al Mahawil General Hospital, Babylon, Iraq

²Ministry of Higher Education and Scientific Research, College of Medicine, University of Thi-Qar, Thi-Qar, Iraq

Corresponding Author*

Imad Abedzaid Mohan Aljanabi

How to Cite the Article:

Imad Abedzaid Mohan Aljanabi, Nada Kadum Kareem and Marwa Habeeb Nazal (2021). Rare Presentation Heterogeneous Pregnancies. *IARJ Med & Surg Res*, 2(2),9-16.

Copyright @ 2021: This is an open-access article distributed under the terms of the Creative Commons Attribution license which permits unrestricted use, distribution, and reproduction in any medium for non commercial use (NonCommercial, or CC-BY-NC) provided the original author and source are credited.

Abstract: It is done and corrected two cases in General Hospital, Babylon, Iraq Vaginal bleeding, scanty discharge that differs from the timing and amount of a normal menstrual cycle and / or abdominal pain may indicate pregnancy loss (uterus or ectopic) in the early stages. Pregnancies with unclear viability to the fetus can be detected by chance during a routine or antenatal ultrasound. For a correct clinical diagnosis, it is important first and foremost to exclude ectopic pregnancy, gestational trophoblastic disease and spontaneous abortion. When evaluating a pregnancy in the womb, a differential diagnosis is made between a normal pregnancy, a miscarriage (complete or incomplete), or an ectopic pregnancy. The susceptibility and location of pregnancy should be determined at the same time during a visit to a pregnant woman with symptoms of bleeding and pain. The single test most useful to distinguish between an uterine pregnancy and an ectopic pregnancy is an ultrasound scan with the-hCG blood test. The primary diagnostic test for women with an ectopic pregnancy is to measure the levels of the hormone hCG in the blood. A negative test excludes pregnancy, including ectopic pregnancy. Detection of a uterine pregnancy with a transvaginal ultrasound in most cases excludes an ectopic pregnancy, because the so-called "ectopic" pregnancy (having an uterine pregnancy and an ectopic pregnancy) is extremely rare — only in 1: 7000-1: 30,000 cases. However, the risk of a possible heterogeneous pregnancy increases with the use of assisted reproductive technologies, when their frequency reaches 1%. Maternal serum β -hCG and high-resolution ultrasound are complementary. Levels of B-hCG in an ectopic pregnancy may be higher or lower than the discriminant level. An abnormal ectopic pregnancy can occur at any level of hCG. To diagnose an ectopic pregnancy, dynamics or urgent hospitalization is required.

Keywords: hCG, pregnancy, heterogeneous, Ectopic, Pelvic ultrasound.

INTRODUCTION

A heterogeneous pregnancy is the presence of two simultaneous pregnancies with separate implantation sites, one of which is a viable intrauterine pregnancy (that occurs in the womb) and the other a non-viable

ectopic pregnancy (that occurs outside the uterus, usually in the fallopian tube).

A variant pregnancy can be just as dangerous as an ectopic pregnancy, and the difficulty is compounded by the fact that most fathers will keep one pregnancy while they have to terminate the other.

An ectopic pregnancy is a type of ectopic pregnancy and occurs in 3.1-8% of all ectopic pregnancy (Xiao, H. M. *et al.*, 2006). The first descriptions of VYB date back to the 17th century, but the diagnosis was established in all cases after the death of the pregnant woman. The first classification of ectopic pregnancy, which provides for the division into ectopic pregnancy, tubal, ovarian and abdominal pregnancy, was published by Levre (1752). With the development of the era of ultrasound, the possibilities of timely diagnosis of SNP have increased significantly, although they have certain limitations.

If ovarian pregnancy occurred during fertilization of the egg in the ovary, it is considered primary, if fertilization occurred as a result of tubal abortion by implanting the embryo - secondary.

The etiology of IDP is associated with inflammatory processes in the uterine polyps (up to 92.5% of cases described for IDP), as a result of which the fallopian tubes undergo functional changes. Among other factors that contribute to the development of IDS, the use of intrauterine contraceptives appears to play an important role, leading to a violation of tubal peristalsis (in the group of women using intrauterine contraceptives, the frequency of IDS increases by 3.5-6 times). "Ovogenesis theory" links an ectopic pregnancy with the early appearance of placental characteristics or increased biological activity of the zygote, which causes the embryo to implant outside the uterus, although it is not a command, but appears to play an important role in the emergence of IDP.

Among the other causes of IDS:

Genetic and genetic factors Echocardiography of early ovarian pregnancy is impossible, because the egg, the yolk sac mimics the follicle or the corpus luteum.

We present our own observation of VYB in a 31-year-old woman K. Patient K went to the hospital with complaints of bloody secretions from the reproductive system and delayed menstruation. From the patient's history it is known that the second pregnancy, from a healthy husband. Neither the husband nor the patient

has any occupational risks. The first pregnancy / miscarriage ended before 12 weeks.

The second pregnancy - the desired pregnancy - came spontaneously. Pregnant woman is not registered with the antenatal clinic. With the delay of the menstrual cycle for two weeks, the patient suffering from the above-mentioned complaints turned to the antenatal clinic at the place of residence, where she was sent to the hospital in KGBUZ "KMKB No. 4" with the diagnosis of early miscarriage that began with an early miscarriage, burdened with the obstetric history.

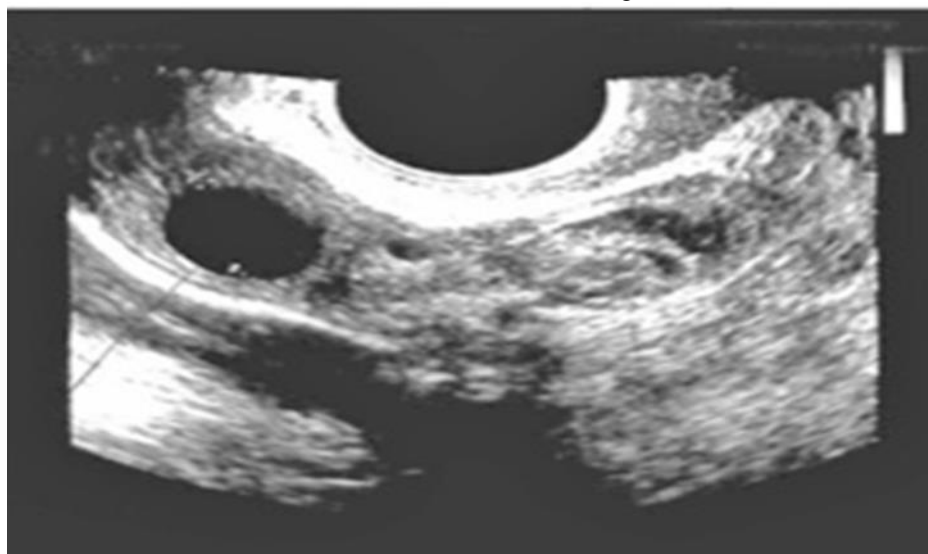


Fig.1

On admission, the patient was referred to a diagnostic ultrasound physician for an ultrasound examination of the pelvic organs. Ultrasound was performed on a Phillips HDI 1500 ultrasound scanner with a vaginal transducer in 2D mode using color Dopplerography.

According to the study: the uterine body is not enlarged to the size of 45x40x45, the thickness of the endometrium is 13.5 mm, the structure of the endometrium is unchanged. The left ovary is b / o, the right ovary is enlarged with a size of 50x42x48mm, a yellow body with a diameter of 17 mm in which a circular formation of 27x24mm is visualized next to the yellow body without clear boundaries, a heterogeneous structure, an anechoic insert with a diameter of 10 mm resembling a fetal egg is visualized in the center of the formation.

At the CDC, intense blood flow was identified along the periphery of the formation. The circumference of the right ovary is not clear and uneven. There is a small amount of fluid, echo signs of an ectopic ovarian pregnancy: data from hormonal studies have shown an increase in the level of chorionic gonadotropin up to 1742.3 IU / l. The woman underwent K. Surgery due to an ectopic pregnancy. Subsequent histological studies confirmed the reality of ovarian pregnancy. With

further control of the hCG level, it was noted to decrease to 287.4 IU / l.

We present the case, since descriptions of IDP in a physician's practice are very rare, and the diagnosis of IDP is always difficult. The difficulties in diagnosing IDP are due to the fact that the development of this type of ectopic pregnancy, as a rule, does not occur (bleeding at the beginning of pregnancy, ovarian apoplexy) and the resolution of ultrasound in the early stages of IDP is low.

Our case demonstrates a good correlation between gynecological, biochemical and ultrasound results of patient with an ovarian pregnancy.

Heterogeneous pregnancy is the simultaneous coexistence of an intrauterine pregnancy and an ectopic pregnancy It is a rare and serious condition that occurs in only 1 in 30,000 spontaneous pregnancies With the advent of Assisted Reproductive Technology (ART) and ovulation induction, the incidence of heterogeneous pregnancies has increased to approximately 1 in 3,900 pregnancies However, obstetricians and emergency physicians are unlikely to consider this diagnosis part of the differentiation in cases presenting with abdominal pain and vaginal bleeding.

Transvaginal ultrasound is the key to diagnosing a heterogeneous pregnancy. However, it still has a low sensitivity because the diagnosis is often overlooked or ignored. So the diagnosis is often delayed, with severe consequences.

In an ectopic pregnancy, implantation occurs outside the uterine cavity - into the fallopian tube, tubal angle, cervix, or abdominal cavity. A pregnancy cannot mature outside the uterus and can rupture or vomit. Early symptoms and signs include pelvic pain, vaginal bleeding, and cervical dislocation pain. When rupture, collapse or hemorrhagic shock may occur. Diagnosis is based on the beta subunit measurement of hCG and ultrasound data. Treatment can be surgical (laparoscopic or laparoscopic) or conservative (methotrexate therapy).

Quantification of the beta-subunit of human chorionic gonadotropin in serum (beta-hCG)

Ultrasound of the pelvic organs Sometimes laparoscopy

An ectopic pregnancy should be suspected when a woman of childbearing age complains of pelvic pain, bleeding from the reproductive system, fainting of unknown etiology or hemorrhagic shock, regardless of the history of sexual activity, contraception and menstrual function. The results of the physical examination, including a pelvic exam, are neither sensitive nor specific.

A ruptured ectopic pregnancy is a surgical emergency because it causes the mother to bleed and increases the risk of death; A quick diagnosis is the key.

The first step is to take a urine pregnancy test, which is 99% sensitive in any pregnancy. If beta-hCG is absent in the urine, and the clinical data do not allow us to confidently assume an ectopic pregnancy, then further examination is not required in a stable condition. If beta-hCG is present in the urine or clinically significant markers, quantification of the beta-hCG subunit and ultrasound should be performed.

If the amount of beta hCG in the serum is less than 5 mU / ml, an ectopic pregnancy is excluded. If an egg is detected in the uterine cavity by ultrasound, an ectopic pregnancy is unlikely, except for women who have undergone antiretroviral therapy (which increases the risk of a heterogeneous pregnancy); In addition, the pregnancy at the angle of the salivary or in the abdominal cavity, according to the ultrasound, may actually be the uterus. Signs of an ectopic pregnancy with ultrasound (detected in 16-32%) include mixed formations (solid and cystic), usually in the region of appendages and free fluid in the posterior void.

If the level of the beta-hCG hormone in the blood exceeds a certain level (the so-called discrimination zone), then an ultrasound examination should reveal the

presence of pregnancy in the womb. This level is about 2000 m units / ml. If the beta-hCG level is higher than the differential values, and the egg is not found in the uterus, an ectopic pregnancy is likely. The use of color Doppler ultrasound can improve the accuracy of the scan.

If the beta-hCG level is below the region of discrimination, and the ultrasound results are ambiguous, there may be a pregnancy from the uterus or ectopic for a short time. If an ectopic pregnancy is suspected clinically (for example, due to bleeding or peritoneal symptoms), then a diagnostic laparoscopy may be required to clarify the diagnosis.

If an ectopic pregnancy is unlikely and the patient is stable, beta-hCG levels can be monitored on an outpatient basis (usually every other day). With a normally developing uterine pregnancy, the values double every 1.4-2.1 days for 41 days. In ectopic (and miscarriage) pregnancies, levels may be lower than expected during the intended pregnancy and not multiplying quickly. If beta-hCG levels do not rise, as one would expect, or, on the contrary, decrease, then the question of the possibility of a spontaneous miscarriage or an ectopic pregnancy should be reconsidered.

It also increases the chance of a heterogeneous pregnancy with a history of pelvic inflammatory disease, and surgical interventions on the pelvic organs (in particular, the fallopian tubes), an abnormal structure of the uterus.

This situation can be fatal, so it's important to be informed. The main danger is that in many cases it becomes possible to diagnose a heterogeneous pregnancy only at the moment of rupture of the fallopian tube (if it is a tubal pregnancy, and it is most often). The fact is that in a single pregnancy, an ectopic pregnancy can be suspected if the B-hCG grows, and we do not see the egg in the uterine cavity (although they should do so in terms of timing and level of the hCG hormone). In a heterogeneous pregnancy, we see an egg in the uterine cavity, and we notice an increase in the pregnancy hormone (which in general gives us a picture of a completely normal uterine pregnancy), and it is almost impossible to see the egg in the tube in the early stages of pregnancy.

In the event of a heterogeneous pregnancy, there are two possible options for the development of events:

➤ A uterine pregnancy develops, and the uterus breaks down.

This condition is manifested by pain and bloody secretions during pregnancy. This is a reason to be admitted to hospital immediately and undergo surgery. Timely surgical intervention often allows you to preserve the pregnancy in the womb and the birth of a healthy baby.

➤ **A uterine pregnancy ends in a miscarriage / non-developing pregnancy, and an ectopic pregnancy continues to develop.**

In the same way, bloody secretions (which persist for a long time after the loss / termination of pregnancy) and pain in the lower abdomen allow suspicion of such a condition. In such a case, it is necessary to take a pregnancy test and donate blood for B-hCG (analysis by cito to see the result as soon as possible) to make sure there is no pregnancy (or it is, and you need to look for it). With high B-hCG values, an ultrasound scan should be performed in order to look for an ectopic pregnancy (to determine its exact location). The next step is laparoscopy and removal of the egg (if it is a tubal pregnancy, this is usually done with the tube). All these manipulations must be performed as quickly as possible.

Ectopic pregnancy occupies a leading position in the structure of maternal mortality, it is in the first place a cause of intra-abdominal bleeding and second in the structure of acute gynecological diseases.

For the first time, an ectopic pregnancy was described in the 17th century, but the diagnosis was made only after the patient's death. The condition of the intrauterine diagnosis of an ectopic pregnancy was recorded in 1812. Until 1870, only 500 ectopic pregnancies were described in the international literature, and the treatment methods used did not give a positive result.

Mortality due to ectopic pregnancy remains high in the twenty-first century, as it ranks second in the world in the structure of maternal mortality, third or fourth in the industrially developed countries of the world, and fifth in the Russian Federation.

Ectopic pregnancy is one of the most common causes of infertility. An ectopic pregnancy does not belong to the studied reproductive losses, however, to this day it remains one of the major problems of reproductive medicine related to a woman's subsequent fertility. After an ectopic pregnancy, many develop an adhesive process in the small pelvis, in 60-80% of patients - infertility, in 20-30% of patients - recurrent ectopic pregnancy.

In recent years, there has been a trend towards an increased incidence of ectopic pregnancy. There are many factors that increase the risk of an ectopic pregnancy: the steady increase in the number of inflammatory diseases of the internal genital organs, the increase in the number of miscarriages, the use of intrauterine contraceptives and hormones, the use of ovulation stimuli and assistance. Reproductive techniques, pre-operative interventions on tubes, tumors and tumor-like formations in the uterus, appendages, endometriosis, genital infancy, endocrine and

vegetative disorders, increased trophoblastic activity, and stress.

Inflammatory diseases in the aetiology of ectopic pregnancy account for 42-80%. In recent years, among the risk factors for an ectopic pregnancy, special attention is paid to sexually transmitted diseases. This relates, first of all, to chlamydial salpingitis, which occurs in 50-60% of patients with an ectopic pregnancy. Inflammatory diseases of the internal genital organs lead to impaired patency, damage to the neuromuscular system of the fallopian tube and neuroendocrine disorders. An equally important risk factor for an ectopic pregnancy is having miscarriages, as nearly every second has a history of it.

The incidence of an ectopic pregnancy using an IUD is 3-4%, which is approximately 20 times more than that of the general population. When taking oral contraceptives that contain progestogens the incidence of ectopic pregnancy increases to 2 per 100 women / year, which appears to be due to the inhibitory effect of progestogens on the membrane Uterine mucosa and slowing down of contractile activity of the fallopian tubes against the background of preserved ovulation. Ovulation continues in 50% of patients who take the mini-pill.

Against the background of taking ovulation stimuli, the frequency of ectopic pregnancy increases to 10%, and with the development of ovarian hyperstimulation syndrome, the risk of ectopic pregnancy increases three times in comparison with the general population.

Previous tube surgeries are also a risk factor for developing an ectopic pregnancy. Often reconstructive plastic surgery is accompanied by a violation of anatomy. This explains the very high (up to 25%) frequency of ectopic pregnancy after these operations. Operations with a high risk of tubal pregnancy are salpingostomy, new salpingostomy, fimbrioplasty, ovariectomy, and tubal anastomosis.

The presence of neoplasms or tumor-like formations in the uterus and appendages changes the topographical relationships of the pelvic organs, which leads to a violation of the function of transferring tubes and the possibility of implantation in places outside the uterus. In addition, the hormonal function of the ovaries may be disrupted, indirectly altering the transfer function of the fallopian tubes.

In endometriosis, violations of the transport function of the fallopian tubes are revealed, which is associated with a change in relationships in the hypothalamus, pituitary gland, ovary and uterus system. Often, endometriosis causes mechanical damage to the tubes, narrowing of their lumen due to compression by ectopic or overgrowth.

Childhood genitalia is one of the causes of ectopic pregnancy, and it is associated with increased length of the fallopian tubes and delayed peristalsis.

Smoking is a risk factor for an ectopic pregnancy. In smokers, the risk of an ectopic pregnancy is 1.5-3.5 times higher than in non-smokers. The mechanism of action of nicotine is the delay in ovulation, changes in the contractile activity of the tubes and the uterus, as well as the weakening of immunity.

Presumably, there is increased activity in the trophoblast in some patients, which changes the internal properties of the fertilized egg, which appears earlier not in the uterine cavity, but in the fallopian tube.

In recent years, there has been an increase in the incidence of ectopic pregnancy in women who deliver in later childbearing age. The risk of an ectopic pregnancy in these patients is 3-4 times higher than in patients under 24 years of age. Happen or occur.

Ectopic pregnancy in women with fallopian tubes is completely normal and has no known risk factors.

The most common form of an ectopic pregnancy is tubal pregnancy (96.5-98.5%). Localization of the ovum in the fallopian tube, according to the United States and Russia, is presented as follows: interstitial division - respectively 2-3% and 2-3%; Isthmus - 11-12% and 10-40%; Ampoule - 80% and 30-60%; Femrial - 4-5% and 5-10% About 5% of pregnancies.

Rare forms of an ectopic pregnancy are difficult to diagnose. Clinically, preoperative diagnosis of ovarian pregnancy, especially progressive, is very difficult. There are no clinical symptoms. Most patients go to medical institutions already at the stage of termination of pregnancy, since in 16% of women menstruation is delayed, and its duration is minimal. Personal complaints are usually a symptom of an uterine pregnancy. An ovarian pregnancy is usually terminated early. Diagnostic signs of ovarian pregnancy: the fallopian tube does not change on the affected side, the egg is located in the prominence of the ovary and is connected to the uterus through its ovarian ligament, and ovarian tissue is located between the membranes.

Cervical pregnancy in the early stages is usually accompanied by hemorrhage, which is associated with the damaging effect of the placenta on the vessels of the cervix. The doctor mistakenly considers the appearance of bloody secretions or bleeding as a manifestation of a miscarriage that has begun to bear a normal uterus, and only the barrel-shaped cervix can be a sign of the localization of the cervix into the egg. Enlarged cervixes as well as uterine fibroids with pregnancy greatly complicate the differential diagnosis. Sometimes a cervical pregnancy is diagnosed during the artificial abortion of the so-called uterine pregnancy, during

which there is profuse bleeding that is not stopped by the oocystectomy. Signs of a cervical ultrasound pregnancy: absence of an egg in the uterus or a pseudo-egg, overgrowth of the lining of the uterus (fallen tissue), heterogeneity of the myometrium. An hourglass uterus, cervical canal dilatation, ovum and placenta tissue in the cervical canal, closed internal pharynx.

An abdominal pregnancy can be suspected if, in the early stages, the woman is concerned about lower abdominal pain and bloody secretions from the reproductive system. On a physical examination, small parts of the fetus and a separate small uterus can easily be palpated. Ultrasound is used for the diagnosis. If the latter is not useful, then the diagnosis is confirmed by radiography, computed tomography and magnetic resonance imaging. The side X-ray of the abdomen shows how the skeletal shadow of the fetus is imposed on the shadow of the mother's spine. Due to the risk of severe bleeding, immediate surgical treatment is recommended. With preservation of pregnancy, the fetus is viable only in 20% of cases.

The timely diagnosis of rare forms of an ectopic pregnancy plays an important role in preventing serious complications that threaten a woman's life and reproductive functions. Until recently, the rare atypical localization of the trophoblast was diagnosed only during surgery. Currently, there are reports in the foreign literature about the possibility of preoperative diagnosis using 3D ultrasound. In the diagnosis of rare forms of ectopic pregnancy - interstitial, cervical, cervical isthmus, ovarian, along with traditional examination methods, 3D / 4D scanning with determination of volumetric blood flow parameters is of great importance.

One particular difficulty in diagnosing an ectopic pregnancy is the combination of an ectopic pregnancy and an ectopic pregnancy. In such cases, ultrasound monitoring and the use of diagnostic laparoscopy allow timely diagnosis of an ectopic pregnancy, improve treatment outcomes and reduce the incidence of complications.

At the present stage, there are several different methods of treating tubal pregnancy: surgical, medical and expectant management of patients.

The generally accepted method of treating an ectopic pregnancy is the surgical method. Over the past two decades, minimally invasive techniques have been used mostly. The laparoscopic method of treating patients with ectopic pregnancy has become the preferred method worldwide in most cases. Laparoscopy has undeniable advantages over laparotomy: small incision, shorter operation duration, minimal frequency of complications, possibility to implement principles of organ preservation, reduced patient stay in hospital, and early physical and social

rehabilitation. Dynamic laparoscopy is particularly indicated if persistence of the placenta is suspected: visual control of the fallopian tube, its sterilization and, if necessary, local administration of methotrexate.

During laparoscopy, both radical (salpingectomy) and conservative plastic surgery are performed. Organ preservation operations in the fallopian tube are possible in the form of a tubal incision, followed by suturing of the fallopian tube wall after removal of the oocyte or salpingostomy, when the incision is not sutured into the wall of the fallopian tube after the oocyte is removed, and the wound heals with secondary intentions. After any of these treatments for an ectopic pregnancy, the fallopian tubes can maintain their normal function.

The nature of plastic surgery depends on the location of the egg. When localized in the pentagonal section, the egg is either squeezed out (moderately painful treatment) or aspirated with an aquapurator. With localization of the egg in the tube ampoule, salpingotomy is also often performed. With prominent ovum localization, salpingotomy or resection of the tube segment with the ovum is performed, with the application of an end-to-end anastomosis. With interstitial localization of the oocyte, laparotomy and salpingectomy with tubal angle resection of the uterus are recommended. With this localization, it is usually not possible to use the laparoscopic approach.

The necessary conditions for laparoscopic operations are a pathological condition of the patient and stable hemodynamics. The absolute contraindication for laparoscopy in an ectopic pregnancy is hemorrhagic shock of the 3-4th degree, which often occurs with blood loss exceeding 1500 ml.

Relative contraindications are: unstable hemodynamics (hemorrhagic shock of 1-2 degrees) with blood loss not exceeding 1500 ml. Interstitial localization of the oocyte. The location of the egg in the extra horn of the uterus; Rupture of the fallopian tube wall. General contraindications for laparoscopy: obesity, pronounced adhesions, cardiovascular and lung insufficiency.

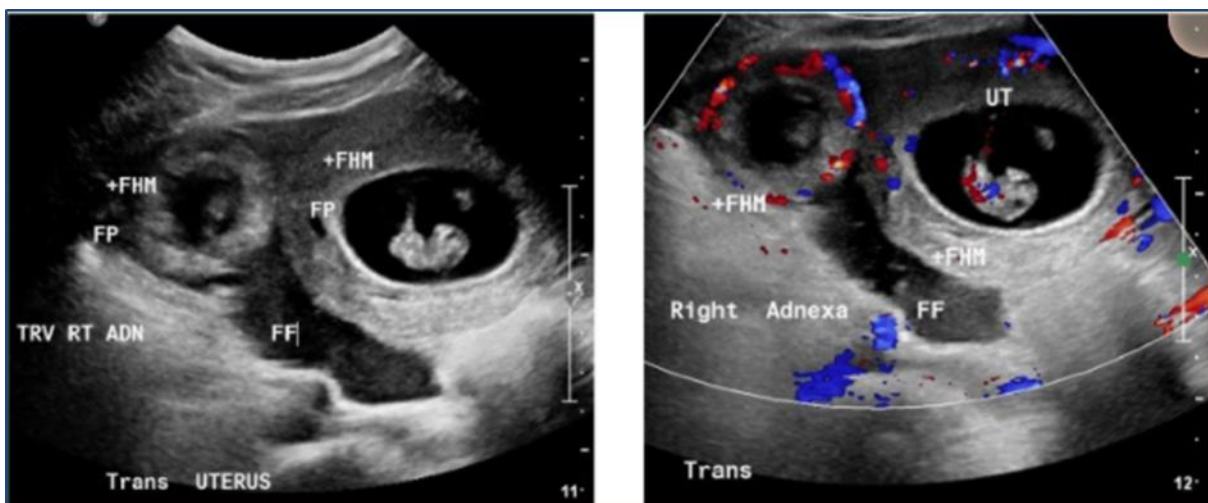
Presentation of case

Case 1

The patient is a 30-year-old female, G3P1011 at 9 weeks and four days before her last feminine period, as per a 9-week and 3-day ultrasound graph, she was introduced to the trauma center and whined of vaginal spotting, lower stomach torment and sickness. She denied any liquid spillage, urinary side effects, fever, chills, dazedness, palpation, or some other indications

The patient had a background marked by earlier hospitalization of pelvic provocative illness (PID) with a captured intrauterine gadget (IUD) around seven years prior. Her IUD was eliminated in the working room. Her way of life around then, Actinomyces, Streptococcus viridans, and negative coagulant Staphylococcus aureus, was developed, and she was treated with doxycycline and ceftriaxone. The patient had no other clinical, careful, or family ancestry.

Pelvic ultrasound (Figure 1) uncovered a solitary direct intrauterine pregnancy for about two months and 4 days with a fetal pulse of 188 thumps each moment (BPM) and an ectopic pregnancy was found in the correct informative supplement of about two months with a pulse. The baby has 180 beats each moment. A lot of free liquid was available, reliable with the extreme blood misfortune saw in low hemoglobin/hematocrit.



Patient number 1. Pelvic ultrasound

Case number 2

Patient is 28 years old, G1P0 at 7 6/7 weeks by her last menstrual period 1/22/14, who initially appeared in ED on 3/16/14 with a complaint of vaginal bleeding, and was diagnosed with a complete miscarriage. At the follow-up clinic visit on 3/18/14, the Beta-HCG level was 22995 mIU / mL increased from 20571 mIU / ml on 3/16/14. The patient denied any complaints including any vaginal bleeding or abdominal pain at the follow-up visit, and was hemodynamically stable.

An obstetric ultrasound examination dated 3/2/14 (Fig2) revealed an intrauterine gestational sac and sub-placenta hemorrhage, as well as a fetal electrode measuring approximately 2.9 mm with no fetal cardiac activity at that time (Fig2).



Patient No. 2. Ultrasound examination

Rehash ultrasound showed that the recently depicted intrauterine pregnancy with fetal terminals was certainly not, at this point seen. In any case, an imploded sore can be found in the lower part of the uterus.

DISCUSSION

Pelvic ultrasound uncovered a solitary direct intrauterine pregnancy for about two months and 4 days with a fetal pulse of 188 pulsates each moment (BPM) and an ectopic pregnancy was found in the correct reference section of about two months and 0 days with a pulse. The baby has 183 beats each moment. A lot of free liquid was available, predictable with the extreme blood misfortune saw in low hemoglobin/hematocrit .

The third ultrasound at 18/3/14 showed an echogenic uterus estimating 12 x 4.6 x 6.5 cm. The endometrium remained astoundingly thick and heterogeneous containing numerous cystic segments. Its thickness arrives at 3.5 cm. There was an increment in veins towards the fundus of the eye. On the left was a 2.5 x 2.5 x 2.3 cm hypoechoic structure with light containers. This was not obviously recognized in the pre-imaging. There was no fluid in the impasse.

An ectopic pregnancy increases the risk of an ectopic pregnancy and future fertility problems. According to one study, the pregnancy rate after conservative or surgical treatment of ectopic pregnancy was 80%, the average time until pregnancy was 9-12

months, and fertility after expectant tactics and surgical treatment was the same. An ectopic pregnancy increases the risk of developing a similar condition in the future by 7-13 times. This means that in 50-80% the next pregnancy will be uterine and in 10-25% it will be ectopic. All patients with an ectopic pregnancy should be advised of the increased risk of a future pregnancy.

CONCLUSION

Doctors ought to consistently safeguard a pregnancy that is heterogeneous in differential analysis in a conceptive patient with stomach torment and signs or manifestations of an ectopic pregnancy. They should focus on the way that clinically or ultrasound affirmation of an intrauterine pregnancy doesn't bar the conjunction of an ectopic pregnancy. A high record of doubt in ladies is required for ahead of schedule and opportune conclusion, and the executives with laparotomy or laparoscopy can prompt a positive effective conveyance result. Heterogeneous pregnancy is conceivable with a typical pregnancy and intrauterine endurance of the embryo is conceivable.

REFERENCES

1. Ackerman, T. E., Levi, C. S., Dashefsky, S. M., Holt, S. C., & Lindsay, D. J. (1993). Interstitial line: sonographic finding in interstitial (cornual) ectopic pregnancy. *Radiology*, *189*(1), 83-87. View at: [Publisher Site](#) | [Google Scholar](#)
2. Callen, P. W. (1988). "Ultrasonography in obstetrics and gynecology," in *Ectopic Pregnancy*, D. Levine, Ed., pp. 1020–1047, Saunders Elsevier, Philadelphia, Pa, USA, 5th edition. View at: [Google Scholar](#)
3. Dadhwal, V., Deka, D., Ghosh, B., & Mittal, S. (2009). Successful management of live ectopic pregnancy with high β -hCG titres by ultrasound-guided potassium chloride injection and systemic methotrexate. *Archives of gynecology and obstetrics*, *280*(5), 799-801. View at: [Publisher Site](#) | [Google Scholar](#)
4. Dhanda, S., Ramani, S., & Thakur, M. (2014). Gestational trophoblastic disease: a multimodality imaging approach with impact on diagnosis and management. *Radiology research and practice*, *2014*. View at: [Publisher Site](#) | [Google Scholar](#)
5. Dundar, O., Tutuncu, L., Mungen, E., Muhcu, M., & Yergok, Y. Z. (2006). Heterotopic pregnancy: Tubal ectopic pregnancy and monochorionic monoamniotic twin pregnancy: A case report. *Perinatal Journal*, *14*, 96-100. View at: [Google Scholar](#)
6. Elito Junior, J., Montenegro, N. A. M. D. M., Soares, R. D. C., & Camano, L. (2008). Unruptured ectopic pregnancy: diagnosis and treatment. State of art. *Revista Brasileira de Ginecologia e Obstetricia*, *30*(3), 149-159. View at: [Publisher Site](#) | [Google Scholar](#)
7. Fernandez, H., & Gervaise, A. (2004). Ectopic pregnancies after infertility treatment: modern diagnosis and therapeutic strategy. *Human reproduction update*, *10*(6), 503-513. View at: [Publisher Site](#) | [Google Scholar](#)
8. Gillespie, A. M., Lidbury, E. A., Tidy, J. A., & Hancock, B. W. (2004). The clinical presentation, treatment, and outcome of patients diagnosed with possible ectopic molar gestation. *International Journal of Gynecologic Cancer*, *14*(2), 366–369, 2004. View at: [Publisher Site](#) | [Google Scholar](#)
9. Guzowski, G., & Sieroszewski, P. (2014). Invasive ultrasound in the management of cervical ectopic pregnancy. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *172*, 7-9. View at: [Publisher Site](#) | [Google Scholar](#)
10. Louis-Sylvestre, C., Morice, P., Chapron, C., & Dubuisson, J. B. (1997). The role of laparoscopy in the diagnosis and management of heterotopic pregnancies. *Human reproduction (Oxford, England)*, *12*(5), 1100-1102. View at: [Google Scholar](#)
11. Monteagudo, A., Minior, V. K., Stephenson, C., Monda, S., & Timor-Tritsch, I. E. (2005). Non-surgical management of live ectopic pregnancy with ultrasound-guided local injection: a case series. *Ultrasound in Obstetrics and Gynecology: The Official Journal of the International Society of Ultrasound in Obstetrics and Gynecology*, *25*(3), 282-288. View at: [Publisher Site](#) | [Google Scholar](#)
12. Panelli, D. M., Phillips, C. H., & Brady, P. C. (2015). Incidence, diagnosis and management of tubal and nontubal ectopic pregnancies: a review. *Fertility Research and Practice*, *1*(1), 1-20. View at: [Publisher Site](#) | [Google Scholar](#)
13. Petousis, S., Margioulas-Siarkou, C., Kalogiannidis, I., Karavas, G., Palapelas, V., Prapas, N., & Rouso, D. (2015). Conservative management of cervical pregnancy with intramuscular administration of methotrexate and KCl injection: Case report and review of the literature. *World Journal of Clinical Cases: WJCC*, *3*(1), 81–84. View at: [Publisher Site](#) | [Google Scholar](#)
14. Pirjani, R., Bayani, L., & Shirazi, M. (2015). Successful local and systemic medical treatment of cesarean scar pregnancy and a subsequent term pregnancy after treatment: a case series. *Iranian journal of reproductive medicine*, *13*(7), 445–450. View at: [Google Scholar](#)
15. Rheinboldt, M., & Ibrahim, S. (2013). Atypical presentation of a large interstitial pregnancy. *Emergency radiology*, *20*(3), 251-254. View at: [Publisher Site](#) | [Google Scholar](#)
16. Tamai, K., Koyama, T., & Togashi, K. (2007). MR features of ectopic pregnancy. *European radiology*, *17*(12), 3236-3246. View at: [Publisher Site](#) | [Google Scholar](#)
17. Tamai, K., Koyama, T., & Togashi, K. (2007). MR features of ectopic pregnancy. *European radiology*, *17*(12), 3236-3246. View at: [Publisher Site](#) | [Google Scholar](#)
18. Tasha, I., Kroi, E., Karameta, A., Shahinaj, R., & Manoku, N. (2010). Prevalence of gestational trophoblastic disease in ectopic pregnancy. *Journal of prenatal medicine*, *4*(2), 26–29. View at: [Google Scholar](#)
19. Xiao, H. M., Gong, F., Mao, Z. H., Zhang, H., & Lu, G. X. (2006). Analysis of 92 ectopic pregnancy patients after in vitro fertilization and embryo transfer. *Zhong nan da xue xue bao. Yi xue ban= Journal of Central South University. Medical Sciences*, *31*(4), 584-587. View at: [Google Scholar](#).