Case Report

Case of Ovarian Tumor with Concurrent Heterotopic Pregnancy

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Introduction
Most common ovarian masses encountered during pregnancy are functional cysts of ovary and luteomas being unique to pregnancy. The other ovarian masses in order are benign cystic teratomas, serous cystadenoma, paraovarian cyst, mucinous cystadenoma and endometrioma.2 Whenever malignancy is suspected in ovarian tumor during pregnancy, it is generally a germ cell tumour or borderline epithelial ovarian tumour.4,5 These are generally of low stage and low grade and consequently prognosis is good.4,5 The incidence of surgery during pregnancy is 1:1312.2. Heterotopic pregnancy is extremely rare and ovarian tumor in a heterotopic pregnancy is extremely rare. Cases of ectopic pregnancy are reported in a case of concurrent teratomas, cystadenomas. However heterotopic pregnancy is not much reported.

Case Presentation
A 35 year old female, G2P2L1 with 7 weeks of gestation presented in casualty with chief complaints of acute pain abdomen on and off since morning. The patient described pain over whole of abdomen, with no aggravating or relieving factors. There was no history of nausea, vomiting, no h/o fever, syncopal attack, bladder or bowel complaints. There was history of bleeding per vaginum. Her previous menstrual cycles were normal. Her obstetric history was uneventful. All previous issues were alive and healthy. There was no significant past, personal or surgical history. On examination she was conscious and coherent. Her BP was 100/84 mm of Hg, pulse rate was 110/minute. The patient was taken for ultra sonography Trans abdominal and transvaginal Sonography showed live intrauterine pregnancy with CRL 1.00 cm corresponding to 7 weeks 1 day. There was a heterogeneous mass in left adnexa measuring approximately 4.3x3.9 cm. The mass showed Gestational sac measuring approximately 0.2 cm corresponding to 4 weeks left ovary was visualised separately. Right adnexa showed complex multicystic lesion measuring approximately 6.1x4.9 cm. It showed septal vascularity However no obvious solid areas where noted within. Right ovary was not separately visualised. Preliminary investigations were done and patient was taken up for laparotomy in view of bilateral adnexal masses. Peroperatively gross morphology was: Right ovarian complex cystic mass ovarian cystectomy was done. Other side salpingostomy was done.

Patient’s post-operative period was uneventful. Histopathology report came out to be serous cystadenoma and left adnexal mass was ectopic pregnancy.

Figure 1: Trans vaginal Sonography shows intrauterine pregnancy with Fetal pole.

Figure 2: Trans vaginal Sonography shows intrauterine pregnancy with Fetal pole.

Figure 3: Trans vaginal Sonography shows heterotopic pregnancy, intrauterine pregnancy and left adnexal pregnancy.
vascularity of left adnexal mass.

always show gestational products in uterus. because of tubal pregnancy. Ultrasound examination can nearly difficult to diagnose clinically. Typically, laparotomy is performed spontaneously by 16 weeks of gestation. A heterotopic gestation is found during pregnancy are corpus luteal cysts and they regress recommendation for conservative management because most of the cysts intervention for fear of above stated complications while others recommend more likely (a) assisted reproduction techniques, (b) persistent or rising chorionic gonadotropin levels after dilatation and curettage for an induced/spontaneous abortion, (c) when the uterine fundus is larger than for menstrual dates, (d) when more than one corpus luteum is present in a natural conception, and (e) when vaginal bleeding is absent in the presence of signs and symptoms of ectopic gestation.

Intrauterine gestation with hemorrhagic corpus luteum can simulate heterotopic/ectopic gestation both clinically and on ultrasound. Other surgical conditions of acute abdomen can also simulate heterotopic gestation clinically and hence the difficulty in clinical diagnosis. The treatment of a heterotopic pregnancy is laparoscopy/laparotomy for the tubal pregnancy.

The incidence was originally estimated on theoretical basis to be 1 in 30,000 pregnancies. However, more recent data indicate that the rate is higher due to assisted reproduction and is approximately 1 in 7000 overall and as high as 1 in 900 with ovulation induction. The increased incidence of multiple pregnancy with ovulation induction and IVF increases the risk of both ectopic and heterotopic gestation.

Heterotopic pregnancy can have various presentations. It should be considered more likely (a) assisted reproduction techniques, (b) persistent or rising chorionic gonadotropin levels after dilatation and curettage for an induced/spontaneous abortion, (c) when the uterine fundus is larger than for menstrual dates, (d) when more than one corpus luteum is present in a natural conception, and (e) when vaginal bleeding is absent in the presence of signs and symptoms of ectopic gestation.

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Conclusion
Ovarian tumors are rare in pregnancy and most common are functional cysts of pregnancy. A spontaneous heterotopic pregnancy can occur in patients who have no known predisposing factor. Early diagnosis has made this disorder amenable to appropriate management. The high-resolution transvaginal sonography is very helpful in the diagnosis of this condition. A spontaneous heterotopic pregnancy can occur in patients who have no known predisposing factor. Early diagnosis has made this disorder amenable to appropriate management. The high-resolution transvaginal sonography is very helpful in the diagnosis of this condition.

REFERENCES

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