ABDOMINAL PREGNANCY

(A Case Report)

BY

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Abdominal pregnancies are rare clinical entities. During the year period from January 1948 to 12th December 1953, 17,936 indoor patients were treated for various obstetric and gynaecological conditions. Of these, there were 58 cases of ectopic pregnancy, two being cases of full term abdominal pregnancy. This incidence corresponds to the figures given by several writers in recent literature, 1.2 per 1,000. The reason for the rarity of the condition appears partly to be due to patients' desire to seek medical aid early and early diagnosis and treatment of abdominal emergencies. At the same time reports of abdominal pregnancies diagnosed preoperatively are also appearing in larger numbers in world medical literature. This again is the result of patients seeking medical attention for conditions which did not worry them before. Radiography and hysterography have also been very helpful with the result that cases, previously seen at the post-mortem, can now be diagnosed in the out-patients' departments of modern hospitals.

The case of abdominal pregnancy, presented here, is unlike any presented so far in the literature. I hope this will help to add to the existing information on ectopic gestations and the marvellous way Nature deals with the complications arising therefrom.

Case Report

Patient H. S., Reg. No. 2444, aged 30 years, Muslim, was seen in the out-patients' department on 15-10-1953 for abdominal pain and lump for 4 years. She had 5 full term normal deliveries, the last being 5 years ago. Only two babies are living, the others having succumbed to diseases of childhood and neonatal period. The menstrual periods were irregular, with amenorrhoea during the last five months. She had noticed a lump in the right lower abdomen for 4 years. Previous to this, she thought she was pregnant and sought admission to a hospital for labour pains. She was discharged as a case of false pains and asked to come over for readmission when pains commenced again. The foetal movements ceased and patient began to menstruate regularly a few days later. Nothing further was done till she noticed a second lump on the left side of the abdomen and had amenorrhoea of 5 months.

Examination: The patient was well nourished. She had two lumps in the abdomen. The one on the right extended from the pelvis upwards and laterally to the right iliac fossa and the lumbar region. It was fixed, hard and tender. On examination per vaginam, a foetal skull with overlapping cranial bones was felt deep in the pelvis, filling up the right fornix and pushing the cervix to the left. The cervix was soft and closed. The uterus could not be defined. The lump on the left was entirely above the pelvic brim, about the size of a full term pregnancy and extended to the left costal margin. It was freely mobile and painless. The right lump was diagnosed clinically as an abdominal pregnancy with a dead foetus. The left one was considered too big to be a 5 months' gestation and thought to be an ovarian cyst or a splenic tumour. The patient was x-rayed immediately.

X-Ray Report: The right lump was undoubtedly an abdominal pregnancy with a dead foetus. The lump on the left also turned out to be a full term foetus presenting by the breech and very high in the abdomen. Hysterogram was not taken in view of the danger of disturbing the uterine pregnancy on the left side. The patient was advised an operation based on the diagnosis of twins in abdominal pregnancy. Fortunately she was not willing for this immediately. She returned for admission on 6-11-53 at 2-10 p.m. with a history of having delivered a male baby by vertex at 8-30 a.m. on the same day. She desired to get the other baby delivered the same way or by operation if necessary.

Clinical Findings on Admission

The lump on the right side was as seen at the first examination. The lump on the left had disappeared. The large puerperal uterus was just below the umbilicus and to the left of the lump on the right.

Operation: Patient was operated on 10-11-53 under spinal nupercaine. Abdomen was opened through a right paramedian incision. The involuting uterus was seen on the left side and a smooth oval mass representing the abdominal pregnancy filled the right side of the abdomen, expanding the right broad ligament. There were no adhesions anteriorly. Above, it was adherent to the caecum and appendix and posteriorly to the pelvic colon and coils of ileum. The fallopian tube was seen coursing along the upper border, its fimbriated end having expanded to merge into the thick capsule of the sac. The round ligament was stretched on the anterior surface. The ovary could not be identified. Thus it was clearly a case of a secondary abdominal pregnancy in the broad ligament. The whole sac with the foetus was removed intact without much haemorrhage or difficulty. The urinary bladder was below and anterior and the iliac vessels and ureter were lateral. The latter was slightly dilated. The left fallopian tube and ovary were normal. The patient was sterilized and abdomen closed. Convalescence was smooth and uneventful.

Pathological Report: Specimen shows a full term mummi-

fied foetus enclosed in a thick capsule from which the placental site cannot be identified. There is no evidence of calcification in the capsule or foetus. An x-ray photograph of the foetus is shown to demonstrate this fact.

Discussion

From the history, physical findings and course of the case, it appears that the patient had a tubal pregnancy which ruptured into the broad ligament, the foetus continuing to develop upto full term. Spurious labour occurred and the abnormality was missed in a local maternity home. The foetus died and was retained in the abdomen in a mummified state. The present pregnancy was carried to term also and a foetus, which was presenting by breech a few days earlier, delivered by vertex normally without any difficulty. A full term dead foetus impacted in the pelvis did not interfere with conception and labour, as one would expect in a case like this. It is quite likely that the patient may have conceived again and delivered normally in future, even if the foetus had not been removed. The ever present danger of sepsis in the dead foetus and obstruction to labour in future, make it imperative that the patient be operated at the earliest opportunity.

Summary

(1) An unusual case of a full-term secondary abdominal pregnancy with a full term uterine pregnancy and normal delivery is reported.

(2) The foetus in the abdominal pregnancy was mummified, and deeply impacted in the right side of pelvis and had expanded the right broad ligament. Its presence did not interfere with conception or labour.

(3) Its presence was clinically diagnosed in the out-patient department and confirmed by radiography.

(4) Operative removal was technically easy and not accompanied by haemorrhage of any severity.

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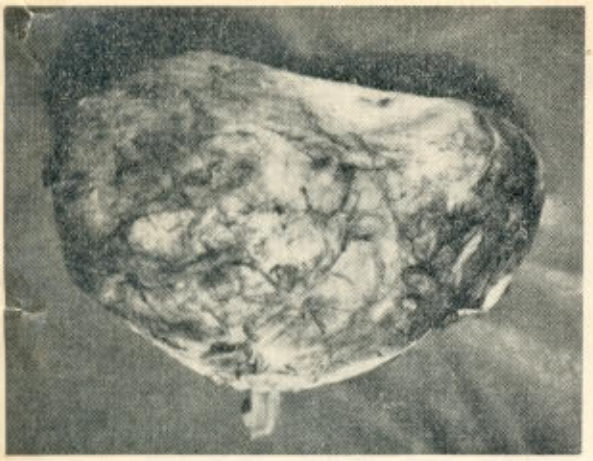
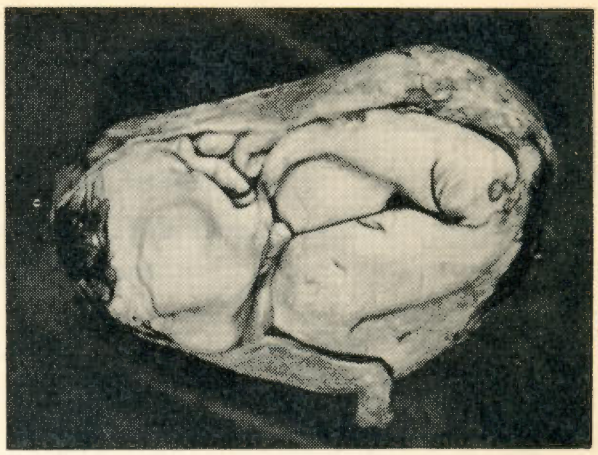
References

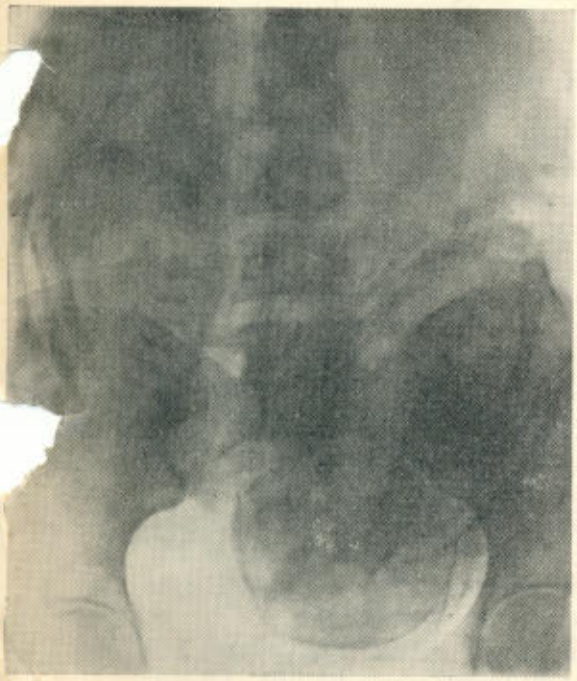
1. Barett: Amer. Jour. Obst. & Gyn.; Vol. 64, p. 1064, 1952.
2. Deming: Amer. Jour. Obst. & Gyn.; Vol. 56, p. 962, 1948.



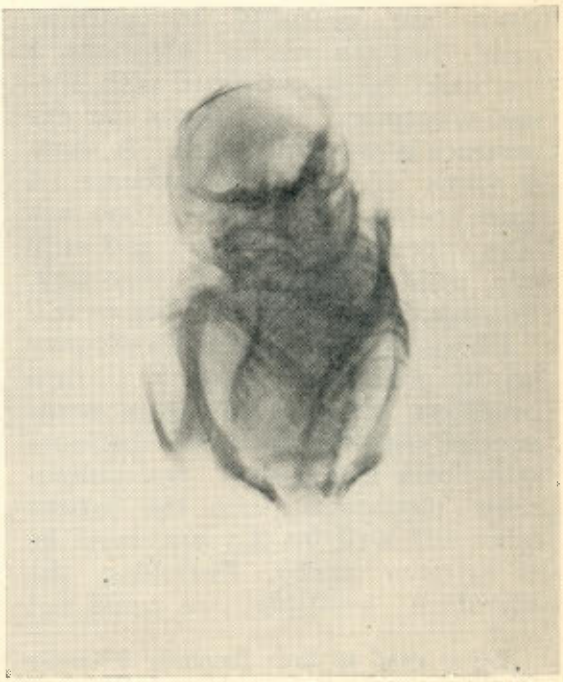
Gestation sac with the foetus, lateral view.



Gestation sac opened, showing foetus.



X-ray of the abdomen showing two foetuses.



X-ray of the specimen.