

UTEROABDOMINAL PREGNANCY

by

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Uteroabdominal pregnancy is the term used when a portion of the conceptus lies inside and a portion lies outside the uterine cavity, and it grows in that situation. This condition occurs following rupture of a defective scar in the uterus, following operation on the fallopian tube or attempted criminal abortion. This is a rare condition and only few cases have been reported in the literature. Perez and Talioferro (1936) quoted by Gepfert (1939) described a case in which, while performing a second caesarean section at the eighth month of gestation for vaginal haemorrhage, the placenta was found to be attached to the lower uterine segment anteriorly with a portion of it growing into the posterior wall of the bladder through the rent in the uterus. The patient died on the table of haemorrhage. Clark (1961) described five cases of uteroabdominal pregnancy; out of these three were subsequent to attempted criminal abortion, one occurred as a result of defective scar from low flap caesarean

section and one following angular implantation of ovum after a partial salpingectomy for tubal ectopic pregnancy.

Case Report

A 26 years old woman, gravida 6, para 4, was seen in July 1963 because of cramp-like pain in the abdomen for three hours. She was seen for the first time at 40 weeks of gestation.

The first pregnancy had ended in abortion in 1956 and the subsequent two pregnancies ended in still-births at 30 and 36 weeks of gestation respectively in 1957 and 1958.

In the 4th pregnancy in January 1960, she had a L.S.C.S. at term in this hospital with an inverted T-shaped incision, vertical limb of the T extending into the upper segment. The indications for the operation were transverse lie of the foetus and leaking membranes. The uterus was remarked to be subseptate at the time of operation. The baby was born alive, weighing 4 lbs. 8 ozs. Puerperium was febrile.

During her 5th pregnancy, the patient reported herself at 35 weeks of gestation in May 1962 with the history of pain in the abdomen for 4 hours, brownish discharge per vaginam for 4 days and loss of foetal movements for 3 days. Physical examination had revealed that she was in a fairly good condition. Her haemoglobin was 9.5 G.% and temperature at admission was 99.6°F. Her blood pressure was normal. Lungs showed signs of bronchitis. Abdominal examination revealed a median sub-umbilical scar. The uterus was enlarged to the size of 34 weeks' pregnancy and the foetus was presenting as breech. No

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uterine contractions were felt but slight generalised tenderness was recorded all over the abdomen. Foetal heart sounds were absent.

Vaginal examination revealed non-dilated cervix. Breech presented at the brim of the pelvis. Offensive brownish vaginal discharge was present, which was cultured. The patient was treated with broad spectrum antibiotics, but continued to have high temperature ranging between 100-104°F. Vaginal swab cultures did not grow any pathogenic organisms. The patient began to look toxic. On the 9th day of admission Pitocin I.V. drip with 5 units in 1000 cc. of 5% glucose (keeping the old uterine scar in view) was started with a view to induce labour but it proved ineffective. On the 10th day, because of inertness of the uterus and deterioration in the condition of the patient abdominal delivery was considered. On 8-6-62 abdomen was opened after excising the previous skin scar. The upper uterine segment scar was found to have ruptured at various places with offensive pus welling out of the uterine cavity. The thin bridges of tissue gave way on mere introduction of fingers. No evidence of scar could be found in the lower uterine segment. Macerated foetus was delivered through the rupture in the upper uterine segment. The placenta was type II placenta praevia and looked unhealthy. Around the rupture, the uterus was firmly adherent to the anterior abdominal wall and the omentum, thus walling it off from the general peritoneal cavity. Sloughing edges of the uterus could not be brought together as the stitches were cutting through the necrotic tissue. In view of extreme sepsis and firm adhesions it was considered inadvisable to break the adhesions and perform hysterectomy or tubal ligation. Hence the abdominal cavity was closed with a rubber drain in the peritoneal cavity. Temperature came down to normal within 24 hours of the operation and the patient remained afebrile subsequently. She was discharged from the hospital on 18th day of the operation. Her husband was advised vasectomy.

Th's time, the patient reported in July 1963, 13 months after her last operation. She had had no pre-natal care. Her

general condition was good. Haemoglobin was 10.5G% and the blood pressure was normal. Abdominal examination revealed uterus of 36 weeks' size pregnancy. Fundal contour was irregular with prominence in the right half. Foetal presentation was breech. Foetal heart sounds were regular and good. No tenderness was felt over the uterine scar. The patient was not in labour. Vaginal examination revealed that the cervical os was closed. In view of her previous history of ruptured uterine scar, abdominal delivery was undertaken on 25-7-63. Abdominal cavity was opened through the previous scar. The dense adhesions between the omentum and the anterior abdominal wall were incised and ligated. Omentum was seen to form a sac just underneath the incision. (Fig. I). As



Fig. 1

Showing the omentum covering the anterior aspect of the gravid uterus.

this portion of the omentum was incised a large amount of liquor amnii escaped into the peritoneal cavity and a foetal elbow was visualized coming out of the uterine cavity. The foetus was delivered as breech through the longitudinal rupture in the upper uterine segment. The placenta was found to be attached to the posterior wall of the uterus as shown in Fig. II. Edges of

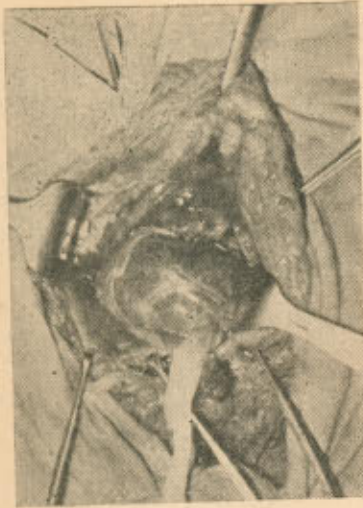


Fig. 2
Showing the attachment of the placenta to the posterior wall of the uterus.

the uterine wound were fibrosed, dry and everted suggesting an old rupture (Fig. III). The rupture extended from about 2"

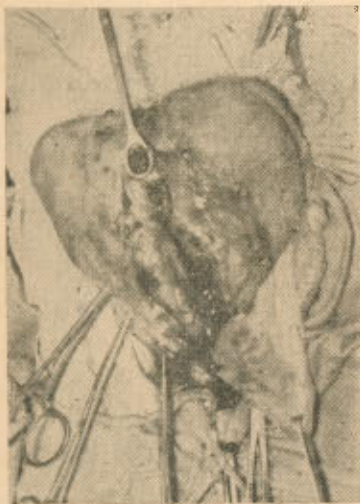


Fig. 3
Uterus after delivery of the foetus and placenta showing the extent of rupture and everted edges of the wound.

below the middle of the fundus uteri to the lower uterine segment. The fibrosed edges

were excised and uterine wound was closed. Sterilization was performed by Pomeroy's technique. The baby was live born, weighing 5 lbs. 1 oz. The patient made an uneventful recovery and was discharged with her baby from the hospital on 10-8-63.

Comments

A rare case of uteroabdominal pregnancy has been described. During second caesarean section suturing of the uterine walls could not be done due to sloughing of the edges. Hysterectomy was not advisable after breaking through the adhesions which were walling off the septic area from the rest of the peritoneal cavity. During third laparotomy since the edges of the rent in the uterus were found dry fibrosed and everted, it was presumed that the drainage of the peritoneal cavity and involution of the uterus brought the edges of the sloughing uterine wall into apposition. The healing took place perhaps by a bridge of thin fibrous tissue which gave way during the early period of next pregnancy and the pregnancy continued to term in a ruptured uterus. The alternative possibility in this case could have been that the edges of the uterus remained apart and never united, the gap being covered by omentum. Conception in that case occurred in a ruptured uterus. Fortunately, the placenta was attached to the posterior uterine wall so that the pregnancy could continue to term.

In this as well as in other reported cases of Perez, Talioferro and Clark, silent rupture of the uterus took place during early pregnancy and the rupture was discovered only on opening the abdominal cavity at the

time of caesarean section. Extensive and careful search in the literature has revealed no similar case.

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