COMBINED INTRA- AND EXTRA-UTERINE PREGNANCY

(A Case Report)

by

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Simultaneous intra- and extra-uterine pregnancy is one of the rarities in obstetrics. The first case recorded was that of "Duverney", found at autopsy in 1708. The incidence is very low. Some clinics have reported only 2 cases in approximately 13,500 deliveries, i.e. 0.015%, whereas others have arrived at a figure of 1 in 27,500 (0.00275%). Devoe and Pratt cite 2 cases in 13,000 deliveries at the Mayo Clinic. Spragee calculates the incidence as 1 in 30,000 at St. Louis University Hospital. The total number of deliveries in the past 5 years at Lady Hardinge Hospital is 27,295, with one case of combined extra- and intra-uterine pregnancy, giving an incidence of 0.0003%.

Until 1940, 304 cases were reported including German, French, Russian literature, and 2 cases were added by Subodh Mitra (306). In 1956, Vasick and Grable brought the number to 435 and in 1957 to 466. However, a number of cases must have been undoubtedly missed, being treated by different doctors or where the patient has a spontaneous or incomplete abortion with no concurrent symptoms of extra-uterine pregnancy. At a later date, the ectopic pregnancy may precipitate an acute episode necessitating laparotomy.

The consensus of opinion regarding the pathogenesis of combined pregnancy is that it is a binovular pregnancy in which both the ova are fertilized following a single coitus. One ovum becomes embedded outside and the other inside the uterus. It has also been postulated that these ova arise usually from two different follicles in one or both ovaries.

The diagnosis is seldom made correctly before operation. Following spontaneous abortion of a uterine pregnancy the possibility of a simultaneous extra-uterine pregnancy is usually not considered. The persistence of abdominal pain is attributed to infection or retained products of conception. Devoe and Pratt found only 6 cases out of 69 up to 1948, where a correct diagnosis was made pre-operatively (4.3%) and in the remainder uterine pregnancy was diagnosed only at laparotomy. Devoe and Pratt explained the low incidence of accurate diagnosis even at operation on account of the fact that the enlargement of uterus is usually considered to be due to the ectopic pregnancy. Further, the surgeon is not likely to think of the possibility of intra-uterine pregnancy once an

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ectopic pregnancy is found at laparotomy.

Weiner et al. reported a correct diagnosis in 9.9% of the cases, with an average duration of pregnancy at 7.7 weeks.

Case History

Mrs. S. G., aged 34 years, 8th gravida, was admitted in the Lady Hardinge Hospital, New Delhi, on 27-12-62 with the complaints of severe pain in the abdomen for the past 22 days following an amenorrhoea of 3 months (last menstrual period was on 5-9-62). She had 4 full-term normal deliveries and 3 abortions. Last pregnancy ended in the spontaneous expulsion of the products of conception after a 2½ months' amenorrhoea, 1½ years before admission. Her periods were regular, with normal flow t ll Sept. 1962. No history of post-abortal or puerperal sepsis, nterference or vaginal bleeding was available. The first attack of pain was on 5th December '62 which came on while defaecating, following which she collapsed and was revived by various intramuscular injections. The pain persisted and was worse on straining. It was most marked around the umbilicus. She was taken to a local hospital and was treated as a case of subacute intestinal obstruct on with glycerine enemas, turpentine stupes and various antibiotics. Response was not satisfactory. From there she was transferred to a local maternity hospital as a case of pelvic inflammat on. She was discharged from there on 26-12-62 and brought to us on 27-12-62.

On examination patient looked ill and anaemic. Pulse was good in volume 120 p.m., tongue was dry. Respiratory and cardio-vascular systems did not reveal anything abnormal.

Per abdomen. There was obvious general sed distension of the abdomen. No definite mass could be made out, but there was marked tenderness in the lower abdomen, so proper examination could not be carried out. Percussion revealed a resonant note in the epigastrium, but impa red in both the flanks. No shifting dullness could be el cited.

Vaginal Examination. Cervix was pointing forwards, body of the uterus felt enlarged but exact size could not be assessed. There was fullness in the pouch of Douglas and left fornix was extremely tender. Other fornix were clear. Cervix felt very soft and looked blue on speculum examinat on. A provisional diagnosis of ruptured ectopic pregnancy was made and immediate laparotomy was decided on.

Investigations. Temperature, normal; Hb. 6 g.m.%; W.B.C. 9,600 per cu. mm.; Urine, no albumin or sugar; and microscopic nil.

Needling of the pouch of Douglas was done in the operation theatre and old dark blood aspirated, which confirmed the diagnosis. On 27-12-62 at 11-30 p.m. laparotomy was performed. Peritoneal cavity was full of dark blood. There was a mass on the left side of the pelvis formed by the fallopian tube, ovary and intestines. The bowels were much distended. The small and large bowel adhesions were gently separated without much difficulty. The left tube was found to be ruptured near the isthmus from where fresh bleeding could be seen. Uterus was enlarged to 16 weeks' size of pregnancy and diagnosis of intra-uterine pregnancy was made. The right ovary and tube were found to be normal. Left salpingoophorectomy was performed. The other tube was ligated by the modified Pomeroy's techn que. Abdominal cavity was cleared of all blood and blood clots and abdomen closed in layers.

Post-operative. She was transfused with 2 units of compatible blood during and after operation; 48 hours after operation, she developed paralytic ileus which was treated on conservative lines. The response though slow was sat sfactory. On 5-1-63 at 4.00 A.M. patient started having pain in the lower abdomen followed by bleeding per vaginam and expelled spontaneously a foetus of 16-18 weeks' size along with the placenta, terminating the intra-uterine pregnancy. Maximum temperature during the post-operative period was 102°F. High vaginal swabs reported Klebisella group of organisms. Patient responded to oral chloromycetine. Clips were removed on the 8th day. Union was satisfactory. She was treated for anaemia and discharged on 21-1-63 with the Hb. of 10 gm.%.

Histopathological report on the removed specimen:—Ruptured tubal pregnancy, (No. 7569-71/62).

Discussion

The subject of combined intra- and extra-uterine pregnancy has always been of interest because of its rarity and the difficulty in diagnosis. Novak says that if there is a definite enlargement of the uterus in a case otherwise suggesting ectopic pregnancy the diagnosis of combined pregnancy must be entertained, particularly if there is no uterine bleeding. Correct and early diagnosis is important in order to formulate the correct line of treatment. Cases have been reported of intra-uterine pregnancy going up to term or even both pregnancies advancing, one intra-uterine and the other extra-uterine. Possibility of continuation of intra-uterine pregnancy is there as reported by Devoe and Pratt (29 out of 44 cases). Atypical history with definite enarlgement of uterus, in a case otherwise suspected of ectopic pregnancy, in the absence of vaginal bleeding or unilateral pain should arouse a suspicion of such a diagnosis.

Summary

A case of extra- and intra-uterine pregnancy is discussed which presented as a case of ectopic pregnancy. On laparotomy intra-uterine pregnancy was diagnosed which ended in a spontaneous abortion 8 days after operation.

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References

1. Allen Alexander, C.: Am. J. Obst. & Gynec. **65**: 452, 1953.
2. Armitage, G. L., Armitage, H. V.: Am. J. Obst. & Gynec. **69**: 885, 1955.
3. Devoe, R. W. and Pratt, G. H.: Am. J. Obst. & Gynec. **56**: 1119, 1948.
4. Mitra, S.: J. Obst. & Gynec. Brit. Em. **47**: 206, 1940.
5. Novak, E.: Surg. Gynec. Survey **43**: 26, 1936.
6. Schafer, G.: Clinical Obst. & Gynec. **5**: 875, 1962.
7. Spraguee, J. R. and Sprague, E., A. J. International Coll. Surgeon **16**: 765, 1951.
8. Vasicka and Grable: Obst. & Gynec. Sur. **11**: 603, 1956.
9. Vivano, J. G., Am. J. Obst. & Gynec. **72**: 191, 1956.
10. Winer, A. E., Bergman, W. D., Fields Charles. Am. J. Obst. & Gynec. **74**: 170, 1957.