RUPTURE OF ANGULAR PREGNANCY

(A CASE REPORT)

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Despite an abundant literature on the subject of ectopic gestation, there have been only four references to angular pregnancy scattered through obstetric literature. Few obstetricians, however, appear to recognize the condition as a specific clinical entity. Rupture of angular pregnancy is reported very rarely; possibly contributory to the dearth of reported cases may be lack of recognition of this unusual ectopic "variant". In a number of instances rupture of the uterus has occurred (Riddell and Scholefield, 1938; Donald, 1957). The following case report may arouse interest because of its rarity.

Case Report

The patient, S.D., 20 years old Hindu female, gravida nil, whose last normal menstrual period had begun on 20th September, 1968, was admitted on 24th March, 1969, in the Gynaecological ward of Kamala Nehru Memorial Hospital, with a history of sharp pain in the right lumbar region and vaginal bleeding for one day. Past history revealed pain of mild degree for several weeks prior to admission. Physical examination revealed a temperature of 101.6°F, pulse 118/mt; her blood pressure was normal and she was anaemic. Uterus was about 20 weeks' size of pregnancy giving an asymmetrical appearance due to a bulging near the right cornual end which was slightly tender on palpation; tenderness was also present in the surrounding area, but there was no guarding; flanks were resonant.

On bimanual examination, the uterus was about 20 weeks' size with a sacculation near the right cornual end which was tender, cervix was soft and blue with slight blood-stained discharge. Patient was kept under observation as a suspected case of pregnancy (cornufundal attachment of placenta to explain the bulging at right cornual end) with appendicitis or pelvic peritonitis.

Her haemoglobin was 6.5 gm%; blood picture was microcytic and normochromic; total W.B.C. count was 5000/cmm and differential count was P 60, L 40. Urine showed presence of occasional pus cells and epithelial cells.

She responded to conservative line of treatment, but on 28th March, 1969, she started having agonising pain in the abdomen again. Abdominal examination revealed generalised tenderness all over the abdomen and generalised guarding, more in the right iliac fossa. The guarding and tenderness were so marked that the uterus was not felt separately per abdomen. The flanks were slightly dull on percussion; bowel sounds were present. On bimanual examination, the exact size of the uterus could not be made out because of the guarding and tenderness; the cervix was soft, internal os was closed, external os

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admitted one finger, and there was fresh blood-stained discharge. Exploratory laparotomy was done. On opening the abdomen, free and clotted blood was found in the peritoneal cavity. Foetus with membranes were lying free in the peritoneal cavity and were taken out; the uterus was enlarged in size and was adherent to loops of gut, which were separated. There was a rupture at the cornual end of the uterus; the tube and ovary of that side were perfectly normal and intact and there was no septum found on exploration of the uterine cavity. Repair of the rent was done. Her post-operative period was uneventful, and she was discharged on 14-4-1969.

Discussion

The term 'Angular pregnancy' has been employed by several writers in order to distinguish it from 'Interstitial pregnancy' on the one hand and 'Cornual pregnancy' on the other, as the latter term is often used to describe a pregnancy in one horn of a uterus bicornis.

One of the most thorough discussions on angular pregnancy is that of Munro Kerr, who defines this entity as a "Gestation in which the ovum becomes implanted in the angle or corner of the uterus either directly over the tubal opening or, more probably, in the interstitial portion of the tube immediately external to that opening". Distinction between angular and interstitial pregnancy is stressed. The critical differential feature is that the fertilized ovum of an interstitial pregnancy essentially develops in the uterine wall (in substantia uteri) whereas in an angular pregnancy it develops towards the uterine cavity. This particular case had asymmetrical enlargement at the right cornu which was thought due to the cornufundal attachment of the placenta. She had pain in the abdomen for few weeks prior to admission and then had severe agonising pain and bleeding per vaginam, which can be explained by the angular pregnancy threatening to rupture.

Angular pregnancy usually presents as a severely painful, tender lateral sacculation of the uterus in the 12th to 20th weeks of gestation; vaginal bleeding may or may not be present. There is a marked tendency to abortion. If term pregnancy is achieved removal of the placenta may be very difficult (McElin and LaPata, 1968). Instances of imminent or actual uterine rupture have been reported. Differential diagnosis includes tubal pregnancy, cornual pregnancy (pregnancy in the horn of a uterine bicornis), degenerating myoma, twisted ovarian cyst, appendicitis with lateral flexion of the uterus and pyelitis, spontaneous rupture of the uterine wall in an area of previous operation, i.e. caesarean section, myomectomy. A further entity to be considered in the differential diagnosis has recently been emphasized by Woolam *et al.* (1967) in a report of two uterine ruptures following tubal implantation.

Summary

A case of ruptured angular pregnancy is being reported for its rarity.

References

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