ADVANCED SECONDARY ABDOMINAL PREGNANCY

by

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It is really thrilling even for a seasoned obstetrician to encounter an extra-uterine pregnancy. The survival of such a foetus at term is surely an obstetrical phenomena and hence justifies reporting.

From 1809 to 1933, Hellman and Simon (1935) reviewed 311 cases of secondary abdominal pregnancy, followed closely by Ware (1948) of 249 cases from 1935-1946. Henderson and Wilson (1964) reported 10 cases from 1943 to 1963, Drury (1968) 9 cases from 1955 to 1958, Zuspan (1957) 11 cases from 1951 to 1956 and Kunders (1965) 5 cases from 1953 to 1965.

The incidence of abdominal pregnancy varies from 1 in 1955 (Zuspan) to 1 in 15,000 (Eastman 1956). From July 1965 to August 1969, at the Vani Vilas Hospital, Bangalore, the total number of deliveries was 40,977. We have had only 3 cases of abdominal pregnancy and hence the incidence works up to 1 in 13,659. The number of ectopic pregnancies during the same period were 170, the incidence being 1 in 241. It can be therefore concluded that the incidence of abdominal pregnancy is very rare. Out of the 3 cases, only 1 was diagnosed pre-operatively and had reached term and hence is reported.

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Case Report

Patient, aged 35 years, came to the Out-Patient Department on 22-7-1969 with a history of 9½ months amenorrhoea and vague abdominal discomfort since 10 days.

Previous Obstetric History

Married 20 years. Had 1 full-term normal delivery at home 16 years ago, but the child died 8 years ago of pneumonia.

History of Present Pregnancy

On detailed questioning patient gave a history of fainting attack and severe pain in the lower abdomen when she was 3 months' pregnant, with slight vaginal bleeding. She never had any treatment for it. No history of previous curettage or manual removal of placenta could be elicited.

She was in a good state of health, and heart, lungs, blood pressure and urine were normal.

Abdominal Examination

Inspection: Two definite masses were seen. A suprapubic globular mass 16 to 18 weeks' size, and another larger mass depicting foetal limbs high up in the epigastrium. Foetal movements were easily perceptible.

Auscultation: Uterine souffle was not heard; foetal heart sounds were clearly audible on the right side above the umbilicus.

Vaginal Examination: Cervix was soft, congested and was pointing forwards. Uterus was felt separate, enlarged to 8 to 10 weeks' size, retroverted and freely mobile. Foetal parts were not felt through the fornices. A soft mass was felt in the anterior fornix separate from the uterus and introduction of the uterine sound confirmed the position of the uterus and that it was empty. At this juncture a curettage was done and the report was, endometrium in the proliferative phase.

X-Ray of Abdomen (Fig. 1): Showed

the foetus lying transversely. No soft tissues shadow either of the placenta or uterus was seen. The back was uppermost and the extremities were directed down towards the maternal pelvis. The attitude of the foetus was exceedingly odd, the head and the limbs being at unusual angles. A repeat x-ray after one week showed the foetus in the same attitude. A lateral view of the pelvis was diagnostic, with the foetal parts overlapping the maternal spine. Oxytocin sensitivity test was done but was not confirmatory.

Management

An emergency laparotomy was done on 11-8-69 under general anaesthesia. On opening the abdomen by a right paramedian incision, the foetus was found lying free in the abdominal cavity without any amniotic sac. A female foetus weighing 6 pounds 8 ounces was removed, who cried immediately after cutting the cord. The placenta occupied the suprapubic region, covered by a thick fibrinous capsule. The uterus was in the pouch of Douglas. On tracing the placenta it was found to be attached anatomically to the left tube (Fig. 2). The fimbriae of the left tube and the left ovary were obliterated by the placental tissues and its vessels. After releasing all the omental adhesions, the placenta was removed by ligating the left infundibulopelvic ligament and the mesosalpinx. (Histo-pathology confirmed the primary site of implantation to be tubal). On inspection of the right tube, is was found to be tortuous, and enlarged with fimbrial block. Hence, a right salpingectomy was done. The abdomen was closed in layers.

During operation the patient had 1 unit of blood. She made an uneventful recovery and was discharged on 23-8-1969.

The female baby was mature and alive; it had multiple deformities and lived only for one hour after delivery (Fig. 3). The scalp was covered by the dense amniotic sac like a sailor's cap. There was asymmetry of the face, the right elbow was flexed and the forearm pronated, and flexion was not possible at the right knee. There was scoliosis of the spine. The paediatrician diagnosed this condition as Arthrogrypos is Multiplexa Congenita.

Post-mortem X-ray of the baby revealed no skeletal abnormality. Autopsy was done and there were no macroscopic or microscopic evidence of any other congenital abnormality.

Discussion

This case is interesting as the extra-uterine pregnancy had advanced to term, ending in a live baby, but disheartening as the baby lived for only one hour. Macroscopic and histopathologic reports confirm the primary site of gestation to be the left tube, where rupture had occurred at the third month; only the foetus had been extruded into the peritoneal cavity and the original placental attachment encroached over the whole of the left tube, ovary and infundibulo-pelvic ligament.

The points of general agreement in an advanced extra uterine pregnancy are (Dixon 1960):

1. It is dangerous to mother and child.
2. It is difficult to diagnose.
3. The placenta is the source of danger.

The maternal mortality rate ranges from 20-30% as compared to the foetal mortality rate of 60-90% (Ware 1948). The prognosis of the mother depends on the site of placental attachment and how it is tackled. Various views have been postulated about the management of the placenta which is the crux of the problem. Ware (1948), removed it in all his 20 cases and had a maternal mortality rate of 14.8%. Kunders (1965), from Vellore, states that with improved surgical technique, blood transfusions and antibiotics it is desirable to remove the placenta whenever possible, but she removed it in only 1 out of her 5 cases. The radical view of removing the placenta in every

case is held by Barrett (1952). Cross *et al* (1957) and Bobrow *et al* (1962) are very conservative, and never attempt to remove it. Hreschyshyn *et al* (1961) in 100 cases, removed the placenta in 71.3% and left it in situ in 28.7%. The post-operative morbidity is greater, secondary bleeding occurs and chances of abdominal abscess and sinus formation are there in cases where the placenta is left behind. Yet it is justifiable to leave the placenta if it is attached to the intestines, liver, or if it is so vascular that adequate haemostasis cannot be established. In our case, removal of the placenta was no problem as it was attached only to the tube. Hence, removal of the placenta is advocated if it is attached to the tube, uterus or ovaries (Tamaskar 1967).

The danger to the child is evident. In most series the child was dead or macerated. The incidence of congenital malformations ranges from 30 to 50% and hence the perinatal mortality is also high. The number of children who survive 8 days or longer is only 50% (Hellman 1935). Suter and Wicker (1948) observed that one third of the living viable babies have deformity and one half of them survive 8 days or more. In our cases the baby, although born alive, had multiple deformities and lived for about one hour.

Another problem to be considered is when to operate once the diagnosis is made. As there is foetal abnormality in 50% of cases Hibbard (1957) disapproves of waiting. If the foetus is dead, an immediate operation is advocated by Bobrow *et al* (1962).

Thus, at each stage it can be seen that an extra-uterine pregnancy poses problems not only in its management, but also in the diagnosis. Success in diagnosis depends upon the condition being thought of, although very rare, whenever the pregnancy has passed term or when multiple masses are felt on abdominal palpation. The second factor is more important than the absence of Braxton Hick's contractions, negative oxytoxin test, uterine sounding or hysterogram. Radiological evidence is confirmatory and diagnostic.

Summary

A case of secondary abdominal pregnancy is reported with a live full term foetus which survived only one hour. A few points that pose in the management of this rare condition are discussed.

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See Figs. on Art Paper VIII