FULL TERM ABDOMINAL PREGNANCY

(A Case Report)

by

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Introduction

An extrauterine pregnancy continuing up to full-term with a live child is rare. Hence, this case is reported.

Case Report

Smt. K., aged 31 years, was admitted on 10-3-1969 for treatment of secondary sterility. She had one full-term, unassisted vaginal delivery which ended in still-birth eight years ago. She and her husband were investigated in the infertility clinic of this hospital. She was suspected to have blocked tubes. Laparotomy on 13-3-1969 revealed a right hydrosalpinx and a patent normal left tube, as proved by abdominal tube testing with methylene blue. Salpingostomy of the fimbrial end of right tube and ventral suspension of the uterus by pleating the round ligaments was done; she was discharged on 24-3-69 (eleventh post-operative day) after a smooth post-operative period.

Readmitted on 22-11-1969 (eight months after the operation) with history of four months' amenorrhoea and severe abdominal pain of a month's duration and backache of fifteen days' duration.

Examination revealed an irregularly enlarged uterus of about fourteen weeks' pregnancy; uterus appeared to be retroverted and therefore was 'corrected' easily with the patient in the knee-chest position. But the abdominal pain was persisting for nearly ten days after this. She used to vomit sometimes and needed morphine for the relief of pain. Blood haemoglobin was 7.1 gms. per cent. The pain subsided in a week's time. She was discharged after nearly a month (on 18-12-69) because the pregnancy was found to be growing and the pain had completely subsided.

On 19-1-1970 (two months after the first episode of pain) she attended the ante-natal clinic. Uterus had grown to 22 weeks' size. The uterus was 'rather irregular', but she was normal in all other respects.

Her next visit was nearly three months later (on 11-4-1970). The uterus was 32-34 weeks. There was a prominent nodule of the size of an orange on the right side, which resembled a subperitoneal fibroid. She was hospitalised now because she had vague abdominal pain and also because this was a precious pregnancy. Her expected date of delivery was about the 10th of May. But she did not get into labour at all, therefore on 30-5-1970 (nine months and 28 days) an elective caesarean section was performed.

On opening the abdomen, the foetus was lying in the abdominal cavity enclosed in the amnion and with fair amount of amniotic fluid. The placenta was occupying the site of the left appendages; the left uterine artery was markedly enlarged and was feeding the placenta. The left ureter was very close to the lower pole of the gestation sac (Fig. 1).

A live female foetus was removed from the sac. Since the placenta was closely adherent to the uterus, a hysterectomy was performed.

The baby weighed five pounds and five ounces (2300 grms.). Placenta weighed 400 grms.; length of the cord was 49 centimetres. Mother and baby were discharged on 13-6-1970 after a smooth post-operative period.

The baby had no congenital abnormality. The patient attended the post-natal clinic on 18-8-1970. Baby was normal (Figs. 2 and 3).

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Description of the abdominal findings (Fig. 1)

The uterus was about ten weeks' size and was pushed to the right by the gestation sac. The foetus was lying transverse with the head towards the right side. It could be seen through the transparent amnion. The right tube was oedematous, but was otherwise normal and the fimbrial end was open. The left tube was traceable only partly from the left cornu of the uterus. Most part of the left tube and the whole of the left ovary were not clear. The placenta was lying attached to the left side of the uterus without any morbid adhesions to the other organs.

The left uterine artery was enormously enlarged and was apparently feeding the placenta. The left ovarian vessels and the ovarian ligaments were not identified (Fig. 4).

Pathological Report

1. Sections were studied from different sites of the gestation sac and the placental site. Some of these sections showed ovarian tissue while others showed nothing significant.
2. Section from the small bit of left tube showed decidual reaction.
3. Uterus showed decidual reaction.

Discussion

Extra uterine pregnancy going to term is rare. Clark and others (1966) have reviewed 26 cases of abdominal pregnancy over a period of 18 years and reported that only nine out of 26 cases went beyond 28 weeks. Mitford (1963) reviewed nine African women with extrauterine pregnancy of more than 36 weeks' duration. In five, the foetuses were alive. No mention is made about congenital anomalies. Rao (1970) reported a case of secondary abdominal pregnancy with a live foetus which died later due to multiple foetal anomalies.

In the case reported here the baby was normal and healthy. The primary site of nidation is not clear. Most part of the gestation sac consisted of amnion only and the foetus could be seen through the transparent membranes. Some bits of the gestation sac near the placenta showed compressed ovarian tissue suggesting an ovarian pregnancy. But all the criteria necessary for the diagnosis of an ovarian pregnancy were not present (Greenhill 1965). The more advanced the pregnancy the more difficult it is to decide the site of nidation. All that is evident now is that it is a secondary abdominal pregnancy due to rupture of either an ovarian or a tubal pregnancy. The symptoms of acute abdominal pain which she experienced between 12th and 14th weeks of pregnancy, coupled with a low blood haemoglobin (7.5 gms. per cent) must have been due to rupture of the primary site of nidation. What was thought to be a retroverted gravid uterus at the fourteenth week was the secondary abdominal pregnancy itself. The normal contour of the uterus was absent. She was a puzzle to all the doctors, but none suspected an extrauterine pregnancy because the pregnancy was proceeding normally and the foetus was alive. This is no excuse because in retrospect we recollect that she had the following signs and symptoms which are characteristic of extrauterine pregnancy and which should have provoked a diagnosis of extrauterine pregnancy. They were:

1. Unusual pain for nearly a month in the first trimester and low haemoglobin of 7.5 gms. Her haemoglobin level, four months earlier was 11.5 gms.
2. Absence of Braxton Hick's contraction of the whole mass.
3. Absence of the proper contour of the uterus. The uterus was noted as 'irregular' in all the notes.
4. Persistent transverse lie of the foetus with the back arched towards the upper pole.

5. Failure of the foetus to change its position.
6. Failure of effacement of cervix.
7. Failure of onset of labour.

It turned out to be a blessing in disguise that the correct diagnosis was not made in the early weeks because if that had been done, her pregnancy might have been terminated, thus depriving her of a live healthy baby. The laparotomy was done in good time before the foetus died.

The placenta was attached to the left side of the uterus, fed by the left uterine artery. Hence, hysterectomy was done. Removal of placenta is a problem in these cases. A lot has been written on this subject. In Mitford's series of nine cases (1963) placenta was removed in five patients only. In the others it was left behind. Hreshchyshyn and others (1965) have suggested the use of methotrexate as an agent to hasten absorption of the placenta.

Summary

1. Report of a case of secondary abdominal pregnancy followed up right from the early stage through the full ten months of pregnancy.

2. The pregnancy resulted in a full-term live normal foetus.

3. The difficulties in assessing the site of nidation in such advanced ectopic pregnancy is discussed.

4. The clinical signs and symptoms are discussed and the literature reviewed.

5. Conservative management of a growing extrauterine pregnancy is worth consideration in certain special cases in the light of this case.

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See Figs. on Art Paper VI