ADVANCED SECONDARY ABDOMINAL PREGNANCY

by

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Secondary abdominal pregnancy is the commonest form of advanced extra-uterine gestation. Usually arising after the intraperitoneal rupture or abortion of a tubal pregnancy and retaining sufficient placental attachment for continued development, it can also follow rupture of a primary ovarian pregnancy, secondary rupture of an intraligamentary pregnancy, slow rupture of a caesarean section scar or very rarely following the old procedure of fundectomy. Advanced abdominal pregnancy following spontaneous rupture of uterus is very rare and so the following case is reported:

Case Report

Mrs. S. aged 35 years, came to the out patients department of S. S. Hospital, Institute of Medical Sciences, B.H.U., on 24-4-1971 with the history of amenorrhoea of 11 months, loss of foetal movements, bleeding per vaginam for two months and watery discharge for 10 days and fever since 8 days.

Previous Obstetrical History: She had five full term normal home deliveries and one abortion of 4 months' gestation one year back. Her last full term delivery was 4 years back. Delivery was conducted by an untrained dai, but there was no history of retained placenta or puerperal fever.

Menstrual History: Her previous menstrual history was normal.

History of Present Illness: The patient gave a history of amenorrhoea for 11 months and loss of foetal movements. There was no history of fainting attacks, abdominal pain and vaginal bleeding in early pregnancy. Two months back she had severe pain in lower abdomen which was relieved after one hour and was followed by loss of foetal movement and gradual regression in size of the breasts and reduction in the size of the abdomen to the level of the umblicus. Ten days after the episode of pain she started having slight blood-stained discharge. For the last ten days bleeding had stopped and thereafter she was passing copious foul smelling, purulent discharge and had occasional fever.

Past History: No history of previous curettage or manual removal of the placenta could be elicited.

General Examination: The patient was thin built and pale, with pulse rate of 108/mt, temperature 101°F. and B.P. 90/60 mm. Hg.

Systemic Examination: N. A. D.

Abdominal Examination: A mass of 24 weeks' size and shape of pregnant uterus was felt which was tense, tender, fixed and of varying consistency. One side of the mass was hard, rest of the portion was cystic and on the left side subcutaneous crepitus was present. No external ballottment could be elicited. Lump was dull on percussion and foetal heart sounds were not audible.

Vaginal Examination: Cervix was pushed towards the right side. The anterior lip was soft and the posterior lip was firm. The uterus was bulky and felt anteriorly separate from the mass, which was high-up and its lower border could be reached with difficulty.

Investigations: Blood—Total W.B.C. count 12,000/Cub. mm, p-78%, l-12%, e-9%, M-1%, ESR=62 mm for the 1st hour. Hb=8.5 gms%, Blood group—A, Rh. positive.

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Urine: N.A.D.
Stool: N.A.D.

Vaginal Swab Culture: E. Coli sensitive to Streptomycin.

X-Ray of Abdomen: Showed a dead foetus lying transversely (fig. 1) dorso-superior, high in position, bizzare appearance, Weinbergh sign was absent.

Operation Findings: Laparotomy was done on 30-4-1971 by infraumblical median incision. Gestation Sac was situated anteriorly and was adherent to parietal peritoneum which was thickened. The uterus was situated behind the mass, anteverted and of normal size. The right ovary was cystic. The left ovary and tubes of both sides were normal.

The sac was incised longitudinally in the least vascular area anteriorly and a macerated foetus was removed. Area of the placenta could not be localized properly, the torn cord was floating in the sac. The sac was found to be continous with the uterine cavity. There was a longitudinal rent in the posterior wall of the uterus and the cervical canal could be felt through the rent.

Subtotal hysterectomy with right sided salpingo-oophorectomy was performed, the stump was covered by peritoneum and the raw area of the sac was covered by the omentum. The abdomen was closed in layers. Post-operative recovery was uneventful excepting diarrhoea on the fourth day which was controlled. On the 10th day stitches were removed, wound was infected in the lower part which was treated with antibiotics.

Discussion

The case is interesting as the extra-uterine pregnancy sac was communicating with the uterine cavity posteriorly and there was a vertical rent in the posterior wall. This becomes thus a utero-abdominal pregnancy which is defined as a form of ectopic pregnancy where a portion of the foetus is outside the uterus and a portion inside the uterine cavity or a fistulous communication between foetal membranes and endometrial cavity which would permit the passage of amniotic fluid or the foetal appendage.

The probable aetiology of such cases is attempted criminal abortion, defective scar in the uterus or angular implantation of ovum (Clark and Bennett, 1964). But in the present case patient did not notice the time of rupture probably due to mild attack or very gradual yielding of the uterus. Patient started noticing the symptoms when spurious labour started two months back after which the foetus died and signs of pregnancy started regressing. Copious purulent discharge was due to infection of the sac from the surrounding bowel and maceration of the foetus, which came out through the cervix due to fistulous communication between the sac and the uterus. Probably the placenta was also expelled out of the uterus through the cervix without the knowledge of the patient. The possible explanation of rupture of the uterus in this case is that she had all deliveries at home conducted by untrained Dai who may have injured the uterine wall repeatedly as they are also in the habit of doing manual removal of placenta resulting in weakness and thinness of posterior wall.

Summary

A case of advanced extra-uterine pregnancy following spontaneous rupture of the uterus has been reported and discussed.

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References

1. Clark, J. F. J. and Bannet, R. C.: Am. J. Obst. & Gynec. 81: 298, 1964.
2. Dixon, H. G. and Steward, D. B.: B. M. J., 2: 1103, 1960.
3. Drury, K. A.: J. Obst. & Gynec., Br. Cwlth. 67: 455, 1968.
4. King, G.: Am. J. Obst. & Gynec., 67: 712, 1954.
5. Padma, K. and Rao, R.: J. Obst. & Gynec. India, 15: 521, 1965.
6. Quilliam, T. A.: Post Grad. M. J., 24: 482, 1948.
7. Ware, W. H.: Am. J. Obst. & Gynec. 55: 561, 1948.
8. Zuspan, F. P.: Am. J. Obst. & Gynec. 74: 259, 1957.