ADVANCED ABDOMINAL PREGNANCY

(Two Case Reports)

by

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An abdominal pregnancy is one in which the placenta is attached to some portion of the peritoneal cavity rather than in the tube or the uterus. Advanced abdominal pregnancy is still rarer. Some workers (Rajoo and Maddimsetti, 1943; Clark Bourke, 1959) call abdominal pregnancy as advanced when pregnancy continues for more than 12 weeks and others (King, 1954) use this term for pregnancy advanced to 28 weeks or more. Rao (1972) recently reported delivery of a living foetus in an advanced abdominal pregnancy.

The incidence is quoted differently from 1 in 2081 deliveries (Beacham and Beacham, 1946) to 1 in 15,000 deliveries (Eastman and Hellman, 1961). The reported incidence in India is 1 in 13,842 (Naidu *et al,* 1960), 1 in 4,300 (Devi, 1961), 1 in 6,809 (Begum, 1968).

The author is fortunate to come across two such cases in a short span of two years. Because of rarity, both cases are reported below.

Case 1

Mrs. B.P., aged 20 years, a Hindu female from a neighbouring district was admitted into the Assam Medical College Hospital. She had a pregnancy of 290 days and was in 'labour' for seven days. This was her second pregnancy. Her first pregnancy was a normal one and had full term normal labour about two and half years back. In both these pregnancies she did not have any antenatal care.

On enquiry, it was revealed that she had an acute attack of pain in the right lower quadrant of the abdomen when she was two months' pregnent. There was no history of vaginal bleeding. The pain subsided after some indigenous medication. Pregnancy began to advance 'uneventfully'. One day, when she was seven months pregnant, she had a fall. This caused her severe pain in the abdomen lasting for about fifteen days. But this subsided after similar 'treatment' as before. Now, since last seven days, she had 'labour' pain without any progress. Initially, she was hospitalised in the district hospital for treatment. Later, when there was no progress of labour in spite of oxytocic drugs, she was referred to this hospital. Till arrival in this hospital, she was reported to have felt the foetal movements.

On examination, her blood pressure was 110/70 mm Hg., pulse 106/minute with moderate volume. There was no pallor. Systemic examination did not reveal any abnormality.

Obstetrical examination showed that she had rather a tense and tender abdomen which made the examination difficult. On careful examination, though the uterine size could not be properly assessed, a transversely lying foetus of term size could be defined. The head was quite high up at the level of the umbilicus. Foetal heart sounds were absent. There was no free fluid in the peritoneal cavity. Cervix was found to be long, firm and almost closed. No vaginal bleeding was noted. While examining vaginally, a thick soft mass of tissue was removed from the vagina. This tissue was

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confirmed to be a decidual cast on histological examination.

Previous history of a fall, high and abnormal position of the foetus and extremely tender abdomen led us to suspect the case to be ruptured uterus.

The patient was kept under observation for a couple of hours, and then it was decided to operate.

Findings at laparotomy: The parietal peritoneum in the incision line was densely adherent to the underlying gestation sac. There was no blood in the peritoneal cavity. After separating the adhesions a longitudinal incision was made on the gestation sac. The amniotic fluid was clear. A male stillborn baby was removed from the sac. Intestines, colon and omentum were found to be adherent to the wall of the sac. On an attempt to remove the placenta, profuse haemorrhage ensued threatening the life of the patient. Condition of the patient suddently deteriorated. Hot compression packing and quick exicion with ligation of the sac along with the placenta, however, controlled the bleeding. On inspection, the left tube and ovary were found to be normal. Only a small portion of the fallopian tube on the right side could be traced in one of the ligated stumps. The rest of the tube and the right ovary could not be demonstrated either in the right broad ligament or in the removed specimen of the sac. The condition of the patient also did not permit us further exploration. There was troublesome oozing of blood from the extensive raw surfaces left behind. Abdomen was closed after packing with a large gauze. Drainage tube was put through the abdominal wall.

On examination of the foetus, no congenital abnormality was found. The weight of the baby was 5 lb. 6 oz.

As expected, her postoperative period was very complicated. In spite of broad-spectrum antibiotics, irregular rise of temperature, often as high as 103-104 degree F., was a constant feature. At the end of a week there developed a lump in the abdomen at the level of the umbilicus with pain and tenderness. This had to be drained. She had dysuria for the first postoperative week. After removal of the abdominal stitches, there was wound sepsis. For a long time after the removal of stitches, a sero-sanguinous fluid was almost constantly discharged through the lower end of the incision scar. She was discharged from the hospital on the 36th postoperative day completely symptom free.

Follow-up: This patient gave birth to a full term male living baby normally exactly after one year in this hospital.

Comments

Beacham and associates (1962) state that the diagnosis should not be difficult if pregnancy has advanced beyond four and half months. They have stressed upon the good antenatal care. In spite of symptoms suggestive of an ectopic pregnancy when she was two months gravid, diagnosis was missed in this case.

Raju *et al,* (1962) reporting 13 cases could make out the uterus separate from the abdominal mass in all the cases. This was not so in the case reported here. Tense and tender abdomen did not permit the palpation of the uterus well. Feeling of a firm and closed cervix, though characteristic, is by no means conclusive. The finding of a piece of unidentified tissue in the vagina was ignored for 'membrane' like substance.

However, it is felt that proper history-taking, careful physical examination and with a high index of suspicion, diagnosis of an abdominal pregnancy should not create much of a problem.

That an injudicious attempt at removal of the placenta may often be a serious mistake is well-examplified by the case cited here.

Case 2

Mrs., A.P., a Hindu female aged 26 years, was admitted into Assam Medical College, for a lump in the abdomen for about one year. She was a mother of two children. Both were normal deliveries. The age of the last child was five years. She had an abortion about one and half years back.

On enquiry, it was found that she had normal menstrual cycles for 3 or 4 months following the abortion. Then she had amenorrhoea for 7 months. She felt foetal movements from the fourth month of this amenorrhoeic period, and continued to feel it till the seventh month when she was suddenly ill with pain in the abdomen, fever, etc. She was then treated in a district hospital. Since then foetal movements were not felt by her. Gradually she improved from her illness and was discharged from the hospital. As stated by her, the abdominal lump gradually subsided to the present size. Menstruation restarted normally. Her last normal menstruation was 28 days back.

On examination: She was slightly anaemic. There were no other significant systemic changes on physical examination. But, on abdominal examination there was an oblong midline suprapubic lump of the size of 16 weeks' gravid uterus, of firm consistency without any obvious contractility. No tenderness on the mass was elicited. Percussion note was dull on the mass. There was no evidence of peritoneal fluid. Because of tenseness of the lump, foetal parts could not be felt clearly nor foetal heart sounds could be heard. On vaginal examination, the lump appeared to be uterine with tenderness in the fornices which were deep without bulging. Cervix was closed and healthy. No vaginal bleeding was noted.

The case was diagnosed clinically as 'missed abortion.'

A skiagram of the abdomen showed a foetal shadow but the radiologist could not exactly locate its position. This was followed by a hysterogram which revealed its extra-uterine position. Then a laparotomy was decided upon. At laparotomy by a midline subumbilical incision morbid adhesions to the peritoneum were encountered. Urinary bladder was markedly pulled up and entangled in the midst of adhesions. Fortunately, no damage was done to the bladder. After releasing the bladder, a macerated foetus was extracted from a pouch bounded all around by colon and intestines. An attempt to search for the placenta, site of tubes, ovaries and uterus was not possible as the pelvis was found to be completely sealed and frozen for any exploration. For fear of causing damage to the vital structures, search was abandoned and the abdomen was closed.

'Not-doing-well' type of postoperative period was the constant feature for her for about a month. However, she was discharged from the hospital symptom-free. This patient could not be traced later.

Comment

History, clinical features and examination of this patient were not suggestive of an ectopic gestation. She had a short period of illness during her early pregnancy, but it was not of an acute nature nor typical to take into account. Interestingly, she started her normal menstruation subsequently, which was in favour of extra rather than an intrauterine pregnancy. Oblong midline uterine type of swelling mislead the diagnosis in favour of missed abortion. Suspicion of abdominal pregnancy arose only after radiological investigations.

The primary site of pregnancy could not be detected.

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