SECONDARY ABDOMINAL PREGNANCY

by

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Introduction

Strictly speaking, abdominal pregnancy includes only those cases in which the gestation is free in the peritoneal cavity rather than between the leaves of the broad ligaments. According to Eastman (1966) abdominal pregnancy occurs more frequently than previously thought. Beacham and his colleagues (1962) have reported an incidence of abdominal pregnancy as 1 in 3373 births. This figure is in close agreement with that of Crawford and Ward (1957), of 1 in 3161 births. Primary implantation of the ovum on the peritoneum is extremely rare. According to Eastman (1966) conclusive proof of a primary abdominal pregnancy was that of Studdiford. Most of the cases are secondary to an early rupture of a tubal pregnancy. Occasionally. however, the ovum after such tubal rupture may continue its development and in such a case it is observed that the amnion has remained intact and the placental chorion was so situated as to escape injury from rupture (Holland and Brews, 1969). A very rare cause of abdominal pregnancy was suggested by King (1932)—it was due to post-operative separation of uterine scar of a previous caesarean section and out of his four reported cases three had escaped into the peritoneal cavity through rent in the uterus. Here a case of secondary abdominal pregnancy is being reported where the pregnancy continued upto six months and at laparotomy no evidence of any tubal rupture or uterine rent was found, so it was thought that the abdominal pregnancy resulted from a tubal abortion instead of rupture.

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CASE REPORT

Mrs. S. D., aged 24 years, married for 6 years was first seen in the gynaecological outdoor for primary infertility. The routine examination was done, and no abnormality was found clinically. Diagnostic curettage with insufflation of tubes during the second half of cycle was advised. Examination of semen of the husband was done, and the report was satisfactory. On tubal insufflation tubes were found to be patent. Curettage revealed that endometrium was in early secretory phase.

The patient came back to the out patient department after 6 months with a history of amenorrhoea of 3 months and complaints of nausea and vomiting. On first examination she was found to be 14 weeks' pregnant with normal blood pressure, weight and no albumin in the urine. She was given iron and vitamin tablets from the hospital and advised to return for next check-up after one month. The patient did not turn up for 3 months—as she went back to her village home in Bihar. For 5 months she kep having pain in the abdomen, off and on, vomiting and low grade fever. The bowel movements were very irregular. She was treated by local doctors but with no relief. She came back to the hospital for these troubles and loss of the foetal movement for the last few days.

On examination, the patient was found very ill, looked very pale, with fever. Blood pressur was normal, and there was no oedema on legs. The abdomen was found enlarged to about 24

weeks of pregnancy, but the feel of the uterus was very firm. The swelling was very tender no definite foetal outline, foetal movements or foetal heart sounds, could be found.

On vaginal examination the cervix looked smooth and conical in type with uterine enlargement of 24 weeks. There was dark discharge found on examining finger. She was admitted in the hospital. Routine examination of blood and urine was done. E.S.R. was high and there was polymorphonuclear leucocytosis and Hb of 8 gms%. The urine showed presence of R.B.C. and plenty of pus cells and albumin. She was treated conservatively with rest, fluids, antibiotics, and analgesic tablets. She did not respond very satisfactorily to this conservative treatment, pain was very severe and vomiting was persistant. She was given suppository to move bowels but the result was poor. A straight X'ray of abdomen was done on the next day. The report was a dead macerated foetus lying transversely across the maternal spines. Whether the gestation was uterine or extrauterine, could not be determined from the skiagram. Some form of abnormality was suspected and an examination under anaesthesia was decided.

Examination under anaesthesia next day with a sound in the uterus revealed a normal sized uterus and the abdominal swelling well above the uterus. A laparotomy was therefore performed by a right paramedian incision. Dense adhesion between intestines, omentum and a bluish white gestation sac were carefully separated. The dead macerated foetus, the gestation sac with a dark coloured liquor amnii inside the sac was removed with some intestinal injuries which were repaired. The blood loss was more than normal. She was given two bottles of blood transfusion. The placenta was firmly attached to large intestines and mesentery on the right side. The cord was cut and ligated as close to the placenta as possible and the placenta was left behind. The post-operative period was uneventful. The union was primary There was a firm lump in the right lumbar and iliac regions due to the retained placenta, but the mass gradually became small and after 6 months, only some induration was found on the right side. The menstruation resumed after 3 months and the patient is doing well now without having another pregnancy yet.

Discussion

The diagnosis of an abdominal pregnancy though very difficult can be made if proper history is taken which often gives a clue. In this case the patient was very uncomfortable along with the pain and the symptoms were mostly gastrointestinal. On abdominal palpation the foetus was found to lie in a very high position in the abdomen and almost transversely and the foetal movements were very painful. The radiological investigation is a very important method in the diagnosis which often shows the foetus lying transversely in a very high position and the foetal spines overlapping the maternal spines. The detection of Braxton-Hick's contraction may enable one to distinguish an uterine from an extrauterine swelling. According to Munro-Kerr (1964) the detection of round ligaments is another important diagnostic point, which was not found in case of extrauterine swelling.

Once a diagnosis is established, laparotomy followed by removal of the gestation sac should be done. Although few cases have progressed to an advanced stage and a good number of viable children have been delivered, it is best to intervene early and not to wait for the foetus to become viable. According to Greenhill (1965) as the pregnancy advances adhesion of the sac with the adjacent organs becomes extensive and most important, the vascular connections, especially in the placental region, are larger, hence the operation may be formidable and frequently precipitates violent haemorrhage. The removal of the placenta in such cases carries the risk of fatal haemorrhage, one should make certain that the blood vessels supplying the placenta could be ligated before its removal. On the other hand,

closing the abdomen and leaving the placenta to take care of itself in the abdominal cavity has proved very satisfactory and is today almost universally accepted.

In this case the gestation sac with the foetus was removed almost completely but the placenta was left behind as its attachment was on the mesentery and intestines. The postoperative recovery of the patient was uneventful.

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See Fig. on Art Paper VIII