ABDOMINAL PREGNANCY

(3 Case Reports)

by

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Abdominal pregnancy is a condition well known but seen with great rarity. It is even more unusual when such a pregnancy progresses to term with delivery of a normal living infant. Hence, these cases of advancedd abdominal pregnancy are reported in one of which a living child was delivered.

The incidence of abdominal pregnancy has been reported as 1: 16370 pregnancies by Douglas and Kohn, (1963) and 1:2081 by Beacham and Beacham, (1963). In our hospital the incidence is 1:21600 full term deliveries. These 3 cases have been seen over a period of 9 years. Jacob and Bhargava (1969) reported an incidence of ectopic as 1 in 250 pregnancies; out of these 1.5 per cent were cases of advanced abdominal pregnancy.

Case 1.

Mrs. Zenabi aged 32 years was admitted on 18.10.1971 with 9 months' amenorrhoea and severe abdominal pain. She was 4th gravidae, with 3 previous full term normal deliveries. She was thin and emaciated. B.P. 110/76 mm Hg., pulse 80/min. Hb. 9 Gms.

On abdominal examination uterus was of 32-34 weeks size with cephalic presentation and absent F.H.S.

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On vaginal examination cervix was hypertrophied firm and os was closed. Plain X-ray showed Spalding's Sign (Fig. 1). She was diagnosed as a case of intrauterine death of foetus. Induction of labour with syntocinon upto 50 units failed. On 22.10.1972 distension of abdomen increased and tenderness was present all over abdomen. Laparotomy was done on the same day. The amniotic sac was seen on opening the abdomen. A mumified female foetus of 2.7 kg. was delivered. Exploration of abdomen revealed placenta adherent to the anterior right abdominal wall, descending colon, intestines and posterior abdominal wall. Exploration of pelvis showed uterus enlarged to 12 weeks' with normal adnexa. Placenta was left inside. Two pints of blood were given during the operation. Stitches were removed on 8th day and pus drained continuously from abdominal wound for two weeks. There was a sinus in the abdominal wound through which degenerated placenta drained in greenish thick fluid. Placental swelling gradually disappeared on the right side of abdomen. Patient was discharged after 2 months. She came for check up after 6 months. Abdomen was soft and no mass was felt.

Case 2.

A Primigravida, aged 32 years came with amenorrhoea of 9 months complaining of abdominal pain. She looked emaciated with cheeks sunken. Heart, Lungs and B.P. examinations were normal. On abdominal examination height of the swelling was the size of 36 weeks pregnancy and foetus was lying transversely high up with head in the right flank. F.H.S. was present. There was a separate swelling of 24 weeks upto the umblicus arising from the pelvis. X-ray A.P. view showed foetus lying transversely in supine superior, vertex in right flank

and entire foetus high up (Fig. 2). Lateral view also showed foetus high up against lumbar vertebrae; intestinal gas intermingled with foetal parts and soft tissue low down indicated placental shadow (Fig. 3). She was diagnosed as a case of abdominal pregnancy. On 3rd day of admission patient had severe abdominal pain and rapid foetal heart. Immediate laparotomy was done. On opening abdomen, the amniotic sac was opened and meconium stained liquor drained. A live female foetus was delivered weighing 2.4 kg. Foetus had left mandibular deformity. The placenta was attached to the posterior wall of uterus and left lateral pelvic wall encroaching on internal iliac vessel and its branches. No attempt was made to remove the placenta as it would have caused severe bleeding. The cord was ligated near the placenta which was left behind. The abdomen was closed in layers. Patient was given three pints of blood during the operation. The patient had severe diarrhoea on 4th postoperative day and went into shock. Resuscitation was done but patient could not be revived and died after a few hours.

Case 3.

Patient, 6th gravidae, age 38 years was seen on 15th August, 1974 complaining of severe abdominal pain and was in distress. She gave history of amenorrhoea of 7½ months and loss of foetal movements. She had two term normal deliveries, one premature delivery, one abortion of 4 months. Last delivery was classical section done for placenta praevia at 32 weeks in some District Hospital.

She was of average built with Hb. 8 gms. B.P. 110/70 mm Hg. and rapid pulse.

On abdominal examination classical section scar was seen. Abdomen was distended, tender, rigid in epigastric area and uterine swelling of 26 weeks was felt on right side with absent F.H.S. X-ray A.P. view showed intrauterine death of foetus (Fig. 4). Patient was given intravenous fluids and Ryle's tube suction done. One pint of blood was also given. After 48 hours, distension subsided. Abdomen was soft and uterine swelling of 26 weeks felt. Uterus was not felt separate from the mass. Intrauterine death of foetus diagnosed and induction with heavy doses of stilboestrol failed. Patient left against medical advise and reported back on 22nd Oct. 1974 with same size of abdominal swelling. Repeat X-ray was taken as shown in (Fig. 5). Skull bones were poorly visualized. Induction of labour with heavy doses of stilboestrol again started without any response. Diagnosis of abdominal pregnancy was suspected and laparotomy done. Before proceeding for laparotomy uterine sound was passed in the uterine cavity in order to know whether pregnancy was intrauterine or extrauterine, but sound went completely inside which misled us that the pregnancy was intrauterine. Abdomen and amniotic sac were opened and a macerated decomposed foetus of 28-30 weeks was taken out. Placenta was high up adherent to the omentum which could be easily separated. It was completely avascular and there was no bleeding. All the intestinal coils were explored and thick amniotic sac was completely dissected out. When the amniotic sac was separated from the anterior wall of uterus there was a longitudinal rent in the fundus, previous classical caesarean scar which had given way. Uterus was of normal size. Right side tube and ovary were healthy. Left tube and ovary were congenitally absent. Salpingectomy and repair of the rent was done. Abdomen was closed and two pints of blood were given. She had no postoperative complications and was followed for 6 months.

Discussion

Preoperative diagnosis of abdominal pregnancy is possible if the condition is kept in mind. Persistent and recurring abdominal pain is a prominent symptom in later months of pregnancy as was seen in all our cases.

Abdominal tenderness, very high position of the foetus or malpresentation, especially transverse lie with distinct foetal heart and uterus separate from gestation sac should arouse suspicion of abdominal pregnancy as was seen in the second case.

A roentgenographic diagnosis of foetal death was made in the first and the third case. Failure to diagnose extrauterine gestation roentgenographically in our first and third cases was partly due to contraction of the gestation sac and partly due to absence of other signs such as

high foetal position with malpresentation as well as intermingling of maternal gas with foetal parts.

Jacob and Bhargawa (1969) confirmed the diagnosis of abdominal pregnancy by passing a sound in the uterus. This was done in the third case but whole sound went inside as there was longitudinal rent in uterus which had given way and that misled us about extrauterine gestation.

Some are of the opinion that it is better to wait a few weeks to get a mature viable foetus if the foetus is living and provided no severe abnormality is noted on skiagraphy. In our second case immediate laparotomy was done irrespective of duration of pregnancy because of the risk of internal haemorrhage due to partial separation of placenta. Some advocate immediate laparotomy, irrespective of period of gestation.

In the first and the second case placenta was left behind as it was adherent to the lateral and posterior wall of pelvis encroaching on the big blood vessels and intestines otherwise it would had resulted in torrential haemorrhage and maternal loss. The first case it is obvious that placental mass slowly regressed in size and discharged as degenerated placental tissue in form of greenish fluid through an abdominal sinus. In the third case placenta was avascular as placental death had taken place more than four weeks back. Placental vessels could easily be ligated as it was completely adherent to omentum as reported by Tamaskar (1967) and Dehner (1972). In this case the embryo had escaped through rent of previous caesarean scar which is very unusual.

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See Figs. on Art Paper VIII-IX