BILATERAL RUPTURED TUBAL PREGNANCY—A VERY RARE CASE

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Introduction

Bilateral tubal pregnancy is very rare but rarer still is the bilateral ruptured tubal pregnancy with one of them becoming secondary abdominal pregnancy and mummification of the foetus.

Beacham *et al* (1962) cited an incidence of 1:3372 births for abdominal pregnancy. Crawford and Ward (1957) reported an incidence of 1:3161 of adbominal pregnancy in general.

Conclusive proof of a primary abdominal pregnancy, however was provided by Studdiford's well documented case which fulfills the criteria upon which proof of such a pregnancy must rest:

(1) Normal tubes and ovaries with no evidence of recent or remote injury.

(2) Absence of any evidence of uteroplacental fistula.

(3) Presence of a pregnancy related exclusively to the peritoneal surface and young enough to eliminate the possibility of secondary implantation following primary nidation in the tube.

Primary abdominal pregnancy is a rarity and little is known of the method of implantation as compared to the secondary abdominal pregnancy. In the tubal pregnancy which is more common the most frequent site of implantation is the ampulla may be due to the mucous plicae present in this situation and hence previous salpingitis is more likely to produce crypts here than elsewhere, besides the ampulla is also the site of fertilization in the first instance.

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Accepted for publication on 17-12-75.

CASE REPORT

Mrs. L. was admitted to Kalpana Clinic on 23-6-1975 with history of distension of lower abdomen, pain in lower abdomen for 15 days and nausea. She had irregular cycles, 15 to 45 days. flow for 7-10 days for last one year. There was history of amenorrhoea for 2 months followed by bleeding per vaginam for 10 days. She was admitted in a Government Hospital and treated as T.B. abdomen and finally referred by a general practitioner as a case of threatened abortion. The pain was intermittent. more of a colicky nature. There was also difficulty in passing urine. There was no history of fainting attacks.

In the past about one year back she had a similar attack of pain and was treated by a general practitioner and a physician. At that time no internal examination was made and since then she had irregular bleeding per vaginam.

Obstetric History: 1 male—8 years—F.T.N.D.—at Hospital—alive; 1 female—7 years—F.T.N.D.—at Home—alive. No. H/O fever or pain in lower abdomen in postnatal period.

Menstrual History: Previous Cycles were regular.

On Admission: Patient ill looking, T-N. P—120/min. vol. good. B.P. 120/80 anemia+ No oedema. Systemic examination, nothing abnormal.

Per Abdomen—Lump in lower abdomen about 24 weeks size more towards left side, cystic in consistency and firm at places, and lower pole not reached. Mobility was restricted. The sur-

face was smooth. margins were regular and there was no tenderness.

Vaginal Examination: Cervix directed downward and backward, firm in consistency, os closed. Uterus A.V. deviated to right side normal size and firm. Lump palpable in anterior and left fornix. Movements of lump transmitted to the abdominal lump and vice versa. No tenderness. Post fx. clear. △ ?Twisted ovarian cyst.

Investigations: Hb.—6.5 gm.%, Blood Group—0 +ve. Urine—Alb. Nil, sugar Nil, 10.12 pus cells/H.P.F. Epithelial cells—few.

Laparotomy performed on 24-6-75. On opening the abdomen plenty of blood and blood clots were removed from peritoneal cavity. There was bilateral ruptured tubal ectopic.

On the left side the sac was situated posteriorly and foetus was fresh. On the right side the foetus was mummified and free in the peritoneal cavity. On the right side the point of rupture was an old one as there were old clots and greenish discolouration like that of the foetus. There was fresh bleeding on the left side where the ruptured ectopic was a fresh one. The bleeding point was clamped and ligated. The ectopic was ampullary in both the tubes and the ampullary and fimbrial part were removed on both the sides. Old blood clots removed from the peritoneal cavity weighed 1½ lbs.

There was one foetus mummified about 14-16 weeks size with placenta, and a second foetus which was small and fresh.

Since the foetus and placenta were dead and free in peritoneal cavity there was not much problem in the management of placenta.

The patient was given one bottle of blood and the postoperative period was good. The wound was clean and she went home on the 11th day. Patient had an uneventful recovery.

Discussion

Mummification is a common occurrence in an abdominal foetus which has been retained for many years without infection of the gestation sac. The liquor gets absorbed and the skeleton can be seen through the wrinkled skin.

In this case the right side ectopic forming a secondary abdominal pregnancy must have occurred about one year back when she had the symptoms but it was missed. Moreover, the haemorrhage must not have been so severe as to give rise to alarming symptoms.

The outstanding feature of an ectopic pregnancy with recently effused blood is extreme tenderness on palpation of the vaginal vault. There was minimum tenderness on examination in this patient.

At the time of laparotomy most conspicuous was the lump palpable per abdomen and though she had an ectopic in the second tube which also ruptured, the symptoms were not alarming enough to produce a state of shock. Probably the clot found at the point of rupture must have prevented further loss of blood.

This case has been reported because of its rarity.

References

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2. Crawford, J. D. and Ward, J. V.: Advanced abdominal pregnancy. Obst. & Gynec. 10: 549, 1957.

See Figs. on Art Paper X