ABDOMINAL PREGNANCY

(A Case Report)

by

SNEHLATA MISHRA,* M.S.

and

PUSHPA GUPTA,** D.G.O., M.S.

In the eleventh century Albucasis, an Arabian, reported the first case of abdominal pregnancy who observed the expelling of foetal parts through a suppurating abdominal wound. Since that time many reports of ectopic gestation have appeared, the majority being of tubal pregnancy. John Bard (1759) performed the first operation for removal of abdominal pregnancy. Despite recent advances in surgery, anaesthesia and blood replacement, abdominal pregnancy remains an extremely dangerous entity with high foetal and maternal mortality.

The true incidence of abdominal pregnancy is difficult to determine and varies widely in different series. Crawford and Ward (1957) found an incidence of 1: 3161 pregnancies. Quilliam (1948) in his extensive review estimated the incidence 1:12500 pregnancies. Eastman (1956) reported 1:15,000 pregnancies. At D.C. General Hospital, James *et al* (1963) during the years 1951-1960 found the incidence to be 1:11000. The incidence of primary abdominal pregnancy has not been calculated because of its extreme rarity. Ruptured ectopic pregnancy is a major gynaecological emergency accounting for 6-7 per cent of gynaecological deaths at present (Harralson *et al*, 1973).

*Lecturer.

**Professor and Head of the Department of Obstetrics and Gynaecology, J. L. N. Medical College, Ajmer (Rajasthan).

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Case Report

Mrs. J., aged 32 years, came to the Gynaecology Out-patient Department of J.L.N. Medical College Hospital, Ajmer on 26-6-1974, with amenorrhoea of 8 months' and high grade fever with chills—1 month.

She had pain in abdomen, profuse vomiting followed by unconsciousness 2-3 months back, which was followed by loss of foetal movements. She had vaginal bleeding for 4-5 days at the same time and she developed distension of abdomen after 2-3 days for which she took some medicine from a doctor and improved gradually. About 1½ months back she developed high grade fever and started passing copious foul smelling discharge per-vaginam. She then went to Pushkar for induction of labour on 25-6-74 and was referred to J.L.N. Medical College Hospital, Ajmer.

Menstrual History

The cycles were regular but they were scanty. L.M.P.—8 months' back.

Obstetric History

She had 3 full-term normal home deliveries, all alive. Last delivery 2 years back, and abortion of 6 months—1 year back. She also gave history of high grade puerperal pyrexia after the abortion. There was no history of previous currettage or manual removal of placenta.

General Examination

Patient was poorly built and nourished. Looked very ill. Pulse 130/mt regular, temperature 103°F, blood pressure 130/80 mm of Hg. Systemic Examination—N.A.D.

Abdominal Examination

A mass of 28 weeks' gestation size was felt, but the outline of uterus was not well-marked. The ballotment was absent and some bony hard part was also felt during ballotment. The lump was dull on percussion and foetal heart sounds were absent.

Vaginal Examination

The Os was patulous and one finger could be introduced into the uterine cavity. The cavity was empty but slight raggedness was felt on left side. The size of the uterus was about 10-12 weeks gestation period. There was fulness in the posterior and in the left fornices and very offensive discharge was present.

Investigations

Haemoglobin 7.0 gm per cent, TRBC 2.4 millions per cu. mm, TLC 10,000, DLC: poly. 75%, lympho. 21%, mono. 2%, and eosino. 1%. Bleeding and clotting Time was normal, blood group 'O'; urine and stool examinations revealed nothing abnormal. On urine culture—B-Coli grown sensitive to Streptomycin and Garramycin; and the same results were on vaginal swab culture.

X-Ray showed dead foetus lying transversely at unusually high position with overlapping gas shadows (Fig. 1).

The patient was having dark brown offensive discharge pervaginam. The vagina was painted with mercurochrome daily and she was treated to improve her general condition so that laparotomy could be undertaken after some days. But on 7-7-1974 some bony part which was found to be tibia and fibula protruded out of the cervical canal and introitus. These bones were slightly pulled but patient went into shock so the part which was hanging out of the introitus was cut.

On vaginal examination it was found that cervical canal admitted one finger. Uterus was about 10-12 weeks size pregnancy and a rent was felt on the side-wall of the uterus on the left side near fundus, through which the foetal-limb bones were protruding into the uterine cavity. A second X-ray (Fig. 2) was taken which showed that the shadow of one leg was missing indicating that it had perforated the uterine wall, and was protruding out of cervical canal and introitus. Two units of blood were given.

Operation Notes

On opening the abdomen on 16-7-74 it was found that the parietal peritoneum was adherent to the sac. Sac was opened, foetal parts and bones removed out of the sac. The placenta could not be identified. The sac was adherent to the fundus of the uterus and there was a rent 2" long at the fundus. The uterus and the peritoneum were sodden and the tissues were very friable. Vesico-vaginal space was identified with difficulty. Total hysterectomy done with great difficulty. Abdomen was closed after putting corrugated drainage tube. The postoperative period was uneventful and patient was discharged cured.

Discussion

A correct diagnosis of extrauterine pregnancy is difficult, but once suspected certain aids are available.

Frequently, a history suggestive of first trimester tubal rupture can be obtained. The local examination of abdomen may disclose generalized abdominal tenderness, irregular contour of abdomen, absent Braxton Hicks' contractions and loud foetal heart sounds, if the foetus is alive. The bimanual examination may disclose a nodularity of Cul-De-Sac. Cervix and foetus do not descend with abdominal pressure. Study of endometrium can be deceiving since absence of decidua does not rule out an ectopic pregnancy.

X-ray shows abnormal presentation, mostly transverse lie, absence of uterine shadow around the foetus, unusual high position of foetus and overlapping of maternal spine in lateral view.

Hysterosalpingography is diagnostic but not without danger. Pitocin test is not conclusive.

The management of the secondary abdominal pregnancy differs according to whether the foetus is alive or dead. When alive some authors advocate laparotomy and removal of foetus, while others prefer waiting if foetus is viable till pregnancy advances upto 36 weeks, provided there

is no foetal abnormality (Crawford and Ward, 1957). But if the foetus is dead it should be removed immediately otherwise the outcome may result in Skeletonization, adipocere, true lithopaedian; or suppuration (Gupta and Sarojini, 1965).

Cases have been reported in which the bones after suppuration were passed either through pouch of Douglas, rectum, bladder, or from abdominal wall.

In this case suppuration occurred in extra-uterine pregnancy sac which was communicating with the uterine cavity near the fundus on left side. The copious purulent discharge was due to the infection of sac from the surrounding bowel and maceration of the foetus which protruded through the cervix from a fistulous opening between the sac and the uterus (abdomino-uterine fistula).

Wahi (1973) reported one case similar to this but there the history of induction of abortion could be elicited while it was absent in this case.

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