ADVANCED BROAD LIGAMENT PREGNANCY

(A Case Report)

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The advanced abdominal pregnancy is now a days rarely seen because of early surgical treatment of ectopic pregnancy; only isolated cases of this hazardous complication are reported in medical literature.

CASE REPORT

Mrs. P.D., aged 30 years, 3rd gravida was admitted on 6-12-1975 with amenorrhoea of about 9½ months approximately, pain abdomen 3 days, bleeding per vaginam off and on 15 days, loss of foetal movements 15 days.

Obstetric History

2 F.T.N.D. both alive males. Last delivery 7 years ago.

Past History

She was admitted in this hospital with acute abdominal pain when she was 3 months' pregnant. She was advised operation but she left against medical advice.

On general examination she was mildly anaemic. Pulse 90 per minute BP 110/70 mm of Hg. Systemic examination did not reveal any abnormality. Hb was 9 gm%. Urine albumin and sugar was nil.

On obstetrical examination the size of the uterus was corresponding to 32 to 34 weeks of pregnancy. Foetal parts were not identified properly; the presentation was breech. Foetal heart was absent. The patient was admitted as a case of intrauterine death.

Syntocinon drip was given four times to induce labour, but she did not have labour pains. On vaginal examination the cervix was long and closed, the body of uterus could not be made out separately from the abdominal mass.

X-ray abdomen showed foetus presenting by breech with evidence of intrauterine death. The shadow of foetal sac was unusually clear because of thickened membranes which at that time thought to be uterine shadow (Fig. 1).

Laparotomy was done on 6-12-1975. On opening the abdomen the foetal sac came into view. It was densely adherent to surrounding structures. There was no blood in peritoneal cavity. The uterus left tube and ovary were normal. On right side there was broad ligament pregnancy. The right tube was densely adherent to foetal sac. Right ovary could not be identified. The sac was ruptured and a dead macerated female foetus weighing. 6 lbs and 2 ozs with no obvious congenital abnormalities (Fig. 2) was delivered. The placenta was attached to the sac posteriorly and laterally. Complete sac with placenta could be removed easily.

Blood pressure fell during operation but she could be revived with blood transfusions, vasopressor drugs and corticoids. The postoperative period was uneventful and she was discharged in good condition on forteenth postoperative day.

Discussion

In this case diagnosis of extra-uterine pregnancy was missed as clinical features were not very suggestive e.g. the foetal parts were not felt superficially and the presentation was breech. Even on x-ray

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examination the shadow of thickened foetal sac was mistaken for uterine shadow.

When repeated attempts of induction of labour by syntocinon drip failed and the abdominal mass was not found contracting and vaginal examination showed a long closed cervix, the diagnosis of extra-uterine pregnancy was suspected.

Summary

The case reported was that of secondary abdominal pregnancy, the primary being in the right fallopian tube as the right tube was found densely adherent to foetal sac and also there was a history of untreated ruptured ectopic pregnancy at 3 months of gestation.

A correct diagnosis can be made by proper history and thorough physical examination. The confirmation of diagnosis can be made by special tests.

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See Figs. on Art Paper II