RARE CASES OF NEAR TERM UNRUPTURED INTRATUBAL PREGNANCY

(Report of 2 cases)

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One wonders how the complicated process of implantation of fertilized ovum, development of placenta and foetal growth can occur without uterus in extrauterine pregnancy. Many factors have been mentioned about abdominal, ovarian and intraligamentary pregnancy but few pregnancies reach to near term and that too unruptured which is an obstetrical rarity.

Two rare cases of unruptured ectopic-tubal pregnancy reaching to near term are reported.

CASE REPORTS

Case 1

A primigravida aged 23 years, married for 7 years was referred from rural maternity home to S.S.G. Hospital, Baroda on 13-4-1976 as a case of extrauterine pregnancy. She had amenorrhoea of 12 months and intermittent vaginal 'spotting' for last 2 months. Her past menstrual history was regular and the date of her L.M.P. was not known. Plain X-ray abdomen in AP view was reported as mature fetus with L.S.A. presentation and intrauterine fetal death. Oxytocin drip was given at rural maternity home to induce labour but there was no response. So she was diagnosed probably as a case of extrauterine pregnancy.

Apart from this, she had normal foetal movements until last one month. She also had pain in lower abdomen more localised to right iliac fossa in addition to 'spotting' per vaginum for last 2 months. There was no history of nausea, spotting per vaginum in early months of pregnancy or no history suggestive of acute abdomen leading to evidence of tubal rupture. She had a fall on ground, 2 months back from a height of 2.5 feet. She had fever for 2 days with rigors.

On physical examination she was anaemic, her pulse was 144/m, temperature was 38.2°C and blood pressure was 130/92 mm of Hg. There was no oedema over feet. Per abdomen the lump was about 36 weeks size uterus, with vertical length of 31 cms and abdominal girth 81 cms at level of umbilicus. It was breech L.S.A. presentation with lower pole high floating above pubic symphysis. Foetal heart sounds were not located even with foetal monitor. There was peculiar crackling sensations felt while doing fundal grip and balloting the head.

On vaginal examination position of cervix was downwards and forwards. External os was patulous and admitted one finger. Internal os was closed. A lump of shape of the uterus of 8 weeks' size firm in consistency was felt in right and posterior fornices? separate from mass palpable per abdomen.

X-ray abdomen in standing position in anterio-posterior and lateral views was taken on 14-4-76, for evidence of extrauterine pregnancy but was reported as an intrauterine pregnancy with

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breech LSA presentation with intrauterine (antepartum) fetal death.

At 4.50 p.m. on same day induction was tried by pitocin drip at the rate of 5 mu/mt and slowly increased upto 10 mu/mt. All the while drip was going on, she had tenderness in right iliac fossa, but margins of lump were regular and remained unchanged. Contractions and relaxations were not appreciated. It was discontinued after 6 hours, as there was no response. The tenderness in the right fossa was decreased and she had no pain in abdomen. Finally she was explored on 15-4-76.

On exploration the lump was found to be of 34-36 weeks uterine size. Parietal peritoneum was adherent to anterior aspect and colon of left side. Both were separated very easily. The uterus of about 8 weeks size was found to be in front of the sac on right side. Uterus was looking normal. No macroscopic evidence of rupture was found. The mass appeared to rise from left side near fundus from ? tube ? ovary. It was attached to infundibulopelvic ligament on the lateral aspect. Tube and ovary on left side could not be identified. On right side the tube and overy were normal. Mass was removed by clamping the left sided cornul structures and left infundibulopelvic ligament. Raw area was peritonised and plication of round ligaments was done. Abdomen was closed.

On examination of sac, it was observed that it had a smooth glistening lining, no haemorrhage or collection of blood clots at any place. Size was 11" x 11". Total weight of sac was 4500 gms. On opening the sac by a window-flap dissection (photograph I) macerated fetus with placenta was found lying on interioposterior aspect. Portion of sac was sent after histopathological examination. Placenta had no significant infarcts or calcification. A portion on one side of sac suspected to be ovary was also sent for histopathological examination. The microscopic picture conformed it to be tube and ovary respectively. X-ray of sac was taken to know the bone age of foetus—it was 40 weeks (Photograph II).

Case 2

A patient aged 20 years, third gravida, was admitted to S.S.G. Hospital, Baroda on 2-9-1974. She had amenorrhoea of 9 months. She was not sure of her last menstrual period. She had discomfort in abdomen for last 8 months and dull aching lower abdominal pain. There was no history of cough, vomiting, pain in abdomen, bowel or urinary complaints. She had 2 full term normal deliveries, last delivery was 8 years back. No history of puerperal sepsis or tube ligation done or history of using any contraceptives. No history of any investigations done during last 8 years for secondary sterility. She had loss of foetal movements since last 1 month.

There was a history of tuberculosis in husband detected 4 years back and treated.

She was a thin and poorly built woman with weight of 35 kg. She was not in shock, but was anaemic. Her pulse was 88/minute and blood pressure was 120/80 mm of Hg. There was no oedema over feet and nothing particular in respiratory and cardiovascular systems. There was no breast secretion. She had lump in abdomen of about 28-30 weeks size hard to firm consistency with partial mobility from side to side. No external ballotment present and foetal heart sounds were not located.

On speculum examination, there was slight bleeding from os; on vaginum eramination cervix was pointing downwards and forwards. There was a lump felt in anterior and right fornices, firm and nodular. Uterus was not defined separately from the mass; left fornix was clear. On rectal examination, lump was felt anteriorly, rectal mucosa was free from mass which was considered to be the uterus.

Her haemoglobin was 9 gms%. Urine was normal. Clotting time was 5 minutes. X-ray chest was normal and X-ray abdomen showed intrauterine foetal death.

On 15-9-1974 Pitocin test was done allowing 5 mu/minute intravenously. No uterine contractions were felt. On 25-9-1974 patient was taken for laparotomy.

On opening the abdomen, peritoneum was adherent to the sac of pregnancy but was easily separable. After separation of peritoneum a yellow coloured thick wall sac was seen. On anterior surface small intestines, iliocolic junction, appendix were adherent. Uterus of 12 weeks size was behind the sac. Left sided tube and ovary were normal. On right side tube was stretched and merged into capsule. Ovary was cystic. (Photograph III).

Posteriorly sac was easily separated from pelvic tissue. Sac was removed by clamping pedicles. Peritonisation was done.

On opening sac, cord placenta and macerated female fetus were seen within thick walled sac.

Discussion

To call a case of ectopic pregnancy as intratubal unruptured pregnancy, it should fulfil criterias as suggested by McElin (1951).

(1) The complete extirpation or separation of foetal sac and products of gestation be achieved by salpingectomy which was possible in these two cases.

(2) There should be no gross or microscopic evidence of tubal rupture.

(3) The ciliated columner epithelium should be demonstrated at some points in the inner lining of sac and also smooth muscle should be found in the sac wall at multiple sites which was present here.

Regarding attachment of placenta Schumann in 1936 suggested that site of placental attachment is inferioposterior aspect of tube in tubal pregnancy because of proximity of the blood supply and greater elasticity of tube at this site. The position of placenta decides diagnosis between intraligamentary and tubal pregnancy. In intraligamentary pregnancy placenta is always above the fetus and enough care must be taken to make incision lower.

The incidence of ectopic tubal pregnancy is 1:300 pregnancy as reported by (Schumann, 1936) but 1% of these go to full term (1:30000).

In S.S.G. Hospital, Baroda, during period of January 1965 to March 1976 there were 32176 confinements and out of these 87 were cases of ectopic pregnancy, 1:359.

The diagnosis was made very late after fetal death. In case of late pregnancy or at term, history of first labour pains with absence of dilatation of cervix, unexplained anteportum fetal death and subsequent prolonged retention of fetus should cause suspicions of ectopic pregnancy. If labour does not start in about two months after foetal death, extrauterine gestation should be thought of which again will be confirmed by unsuccessful attempts at induction of labour with oxytocic drugs.

Summary

There were two interesting cases of unruptured intratubal near term pregnancy with antepartum foetal death. Interesting part in both cases was difficulty in diagnosis and the fact that this is an obstetrical rarity.

Reference

1. Schumann, E.: Am. J. Surg. 33: 570, 1936.

See Figs. on Art Paper IV