SUBACUTE INTESTINAL OBSTRUCTION ASSOCIATED WITH ABDOMINAL PREGNANCY

(A Case Report)

by

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Introduction

Abdominal pregnancy is very rare and may present in the multitude of disguises. Its possibility should be considered whenever a woman in early pregnancy presents with bizarre clinical picture. This is an interesting case, as the patient was brought to the hospital primarily with signs of subacute intestinal obstruction.

CASE REPORT

Mrs. M. D., aged 38 years was admitted as a case of subacute intestinal obstruction.

She complained of gradual distension of lower abdomen for the last 2 months, pain, intermittent vomiting and constipation. She had noticed a lump in the right lower abdomen since this trouble started. She had been treated conservatively for intestinal obstruction in a district hospital, but was later transferred to our Hospital. On admission, she gave a history of exacerbation of the above symptoms during the last 3 days. She had been married for 20 years and had one full term delivery 15 years ago.

Her menstrual cycles were regular. Her last period was 3 months ago, but the exact date of L.M.P. was not known.

Past History: Nil relevant.

Family History: Nil relevant.

On examination, pulse was 120 per minute, temperature was 100°F, Blood Pressure was 90/60 mm Hg. She showed signs of dehydration such as dry tongue and sunken eyes. The breasts were normal with no secretion. Cardiovascular and respiratory systems were normal, Liver and spleen were not palpable.

Abdominal Examination

The lower abdomen was distended and an irregular firm mass was felt in the right lower abdomen which encroached upon the suprapubic region and reached up to the level of umbilicus. The mass was more or less fixed with limited side to side movement and this movement caused pain. The swelling was slightly tender and dull on percussion. The bowel sounds were slightly increased. There was no evidence of free fluid in the abdominal cavity.

Speculum Examination: The vagina and cervix were normal.

Vaginal Examination—Cervix was firm. The uterus was retroverted and normal in size. The abdominal mass was felt separate from the uterus. Because of abdominal findings and history 3 months amenorrhoea, the provisional diagnosis of intestinal obstruction associated with abdominal pregnancy was made, although the possibility of penduculated fibroid or an ovarian tumour could not be ruled out. X-ray abdomen showed slight fluid levels and there was no foetal shadow.

Her Haemoglobin was 10 gms%. Total white cell count was 12500 per cmm.

Differential count, poly. 70%, lympho. 18%, eosino 2%. ESR 55 mm. at the end of 1 hour.

Urine culture and stool examinations were normal.

Blood Urea—24 mg%, Electrolytes were within the normal limits.

Treatment

Intestinal obstruction was treated with intravenous fluids and Ryles tube aspiration. Intra-

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muscular injection of streptomycin ½ gm. twice daily and crystalline penicillin 5 lacs 6 hourly were administered for 5 days. The patient's condition settled to normal on 3rd day, when the temperature had come down to normal and the sign of intestinal obstruction had disappeared. Laparotomy was done under spinal, a week later.

At laparotomy, a gestational sac (6" x 4") was found on the right side of the lower abdomen reaching to the level of the umbilicus. A small foetus was seen through an intact amniotic sac which in turn was covered in its lower half by a thick reddish tissue which was identified as stretched out placental tissue. A loop of small intestine was adherent to the gestation sac at its posterior surface and this was the site of intermittent, subacute intestinal obstruction. The loop of small intestine was gently dissected off the sac. The gestation sac was free of adhesions elsewhere and was clamped at its lower end and was removed. There was no sign of fallopian tube and ovary on the right side. The uterus and left adnexa appeared normal. The pedicle was transfixed with No. I chromic catgut. The abdomen was closed in layers after removing the few clots from the peritonal cavity. The general condition of the patient was satisfactory at the end of the operation. One unit of blood was administered during the operation. The post-operative recovery was uneventful.

Discussion

Abdominal pregnancy should be considered as a possibility when bizarre symptoms and signs are encountered. In this case, the intermittent intestinal obstruction associated with amenorrhoea and recent development of a painful abdominal lump provided the probable diagnosis of abdominal pregnancy.

The genesis of abdominal pregnancy in this case is a matter of conjecture. It most probably followed either tubal abortion or tubal rupture, because there was no sign of a fallopian tube on the right side.