ADVANCED INTRALIGAMENTARY PREGNANCY—REPORT OF TWO CASES AND REVIEW OF LITERATURE

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Advanced broad ligament pregnancy is rare and the diagnosis is practically never made. On review of literature, Champion and Tesstire (1938) were able to find only 69 cases of intraligamentary pregnancy beyond 28 weeks between 1816 and 1938, and they added 1 case of their own. Between 1939 and 1950, Redgewick *et al* (1950) collected 11 cases and reported a case of their own (However, 2 cases were already recorded in series collected by Champion and Tessitore). An analysis of 48 cases has been reported by Peterson (1975) who upon review of literature encountered 38 subsequent cases and 9 missed by others and reported one of their own, thus making a total of about 130 in the world literature.

The rarity of the condition prompted us to report the following 2 cases seen at Medical College and Hospital, Rohtak, Haryana, India during 7 years (1971 to 1977).

Case 1

Mrs. T B. 37 years married for 21 years, P4 + 1, 5th gravida was admitted on 2nd January. 1971 with amenorrhoea of 41 weeks and spotting for 15 days. She never felt any foetal movements. There was no history of vomiting, pain in abdomen or vaginal bleeding earlier. She had 4 full term normal deliveries, last delivery was 15 years back. She had 1 abortion 17 years ago.

Examination: General condition good. Pulse 80/min. B P. 130/90 mm Hg. No oedema.

Abdominal Examination: Mass 28 weeks size of pregnancy. Foetal parts palpable. FHS not heard.

Pelvic Examination: Os closed. Uterus enlarged to 12 weeks size. A diagnosis of secondary abdominal pregnancy was made and laparotomy decided.

Investigations: Hb. 11 G%, Urine—Alb. nil, Sugar nil.

At laparotomy, left intraligamentary pregnancy was found. Fallopian tubes and ovaries were normal except that left tube was stretched over the sac and adherent to it. After opening the broad ligament, macerated, female baby without congenital anomalies was removed. Placenta was attached to the sac posteriorly and superiorly and most of it (75%) could be removed and hemostasis securred.

Patient had uneventful recovery and discharged on 8th day.

Case 2

Mrs. L, 23 years married for 10 years P 1 + 2, 4th gravida was admitted as emergency on 2nd March, 1977, with amenorrhoea of 44 weeks. She had no excessive vomiting, vaginal bleeding or pain in abdomen during the present pregnancy. She had one premature delivery of 7 months gestation 2 years ago, and 2 spontaneous abortions of 2 months each 6 years and one year back.

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Examination: Thin built. pale looking patient. Pulse 80/min. B.P. 120/80 mm Hg. No oedema.

Abdominal Examination: Abdomen was tense with 34 weeks pregnancy with foetus lying transversaly in the abdomen. Palpation was difficult and patient was tender on palpation, FHS not heard.

Pelvic Examination: Cervix not effaced Presenting part high up not made out. Pelvis was contracted.

A preoperative diagnosis of transverse lie with intrauterine death and contracted pelvis was made and laparotomy decided.

Investigations: Hb. 9.0%, Urine: Albumin nil, X-ray abdomen: Transverse lie with foeal death.

At laparotomy uterus was 8-10 weeks size. There was left intraligamentary pregnancy and left tube was stretched over it. Right tube, ovary and left ovary were normal. Left broad ligament was opened and macerated fema'e baby weighing 2 kg. removed. There was excessive haemorrhage. Placenta was attached posteriorly and laterally in the broad ligament and was left in situ. Abdomen closed.

Post operatively patient developed chest infection, peritonitis and septicaemia and she expired on 8th day inspite of antibiotics, corticosteroids and supporative therapy.

Comment

Intraligamentary pregnancy usually occurs in elderly rather than infertile women (Peerson *et al*, 1975). Our first patient was 37 years and had secondary infertility for 15 years, whereas second patient was young (23 years) and fertile. Both patients had advanced left intraligamentary pregnancy, period of gestation being 41 and 44 weeks respectively. Surprisingly both our patients had no abdominal pain, vomiting, or vaginal bleeding, features observed in large number of cases.

Neither of our patients had toxaemia, although in Peterson's series of 48 cases, 9 had toxaemia, out of which 7 were of mild variety. Preoperative diagnosis of secondary abdominal pregnancy was made in the first case. Second patient was tender on palpation, had transverse lie with foetal death, but abnormality in site of gestation was not suspected as it was not kept in mind. At laparotomy there was left intraligamentary pregnancy with normal tubes and ovaries in both the patients.

Peterson *et al* (1975) are of the opinion that placenta is removable and should be removed to reduce mortality from hemorrhage and postoperative morbidity. We could remove placenta (75%) of it in one case. Due to harrowing hemorrhage this could not be achieved in second case who died of sepsis postoperatively. Removal of placenta is desirable so long it can be done without fatal outcome.

Summary

Two cases of advanced left intraligamentary pregnancy, with normal tubes and ovaries are presented. First patient was diagnosed as secondary abdominal pregnancy, whereas transverse lie with intrauterine foetal death was the diagnosis in second case. Both babies were macerated still born, females without congenital anomalies. Second patient, in whom placenta could not be removed due to hemorrhage, had a hectic postoperative time and died on 8th post operative day. Possibility of primary implantation in broad ligament is discussed.

References

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