

SECONDARY ABDOMINAL PREGNANCY—8 YEARS' REVIEW

by

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The author worked in H. P. Medical College, Simla from February 1970-January 1974, and since then in Maulana Azad Medical College, New Delhi. This has given an opportunity to study the cases of secondary abdominal pregnancy that the author personally encountered during the last 8 years. The different incidence in two places suggests that demographic conditions may have an important bearing on the incidence of abdominal pregnancy.

Earlier, Mukherjee and Mukherjee working in H. P. Medical College, Simla, reported only 1 case of abdominal pregnancy amongst the total deliveries of 2359, between 1966-1970. Between February 1970-January 1974 there were 4252 deliveries in that hospital. There were 3 cases of abdominal pregnancies, all seen by the author, the incidence being 1:1417 deliveries.

Between January 1974-January 1978 in Jay Prakash Narayan Hospital (previously called Irwin Hospital), there were 9612 deliveries and only 1 case of abdominal pregnancy was encountered. There were 44 cases of ectopic pregnancies during the same period. The incidence of abdominal pregnancy is thus 1:9612 deliveries and 1:44 of ectopic pregnancies. (2.3% of ectopic pregnancies).

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Case Reports

Case 1

Lithopaedion. A nullipara, aged 28, married for 16 years, presented with a painful abdominal lump of 6 months duration. She had no urinary or gastro-intestinal complaint, and her menstrual cycles had been regular. The abdominal and vaginal findings were suggestive of uterine fibroids. The swelling in the lower abdomen was firm and irregular, fixed and slightly tender. The uterus could not be defined separately from the mass.

At laparotomy, this mass proved to be a lithopaedion, arising from the rupture of right fallopian tube and adherent to the posterior surface and the fundus of the uterus with omental and intestinal adhesions to the lithopaedion. There was no trace of the placenta, cord or amniotic sac.

Case 2

Subacute intestinal obstruction—Mrs. M.D., aged 38, para I, last delivery 15 years ago, was admitted with signs of subacute intestinal obstruction. She had amenorrhoea of 3 months and during the 2 previous months she had suffered intermittent intestinal obstruction which was temporarily relieved by conservative treatment in a district hospital. When the permanent cure was not obtained, she was transferred to our hospital.

On admission, her pulse was 120/minute, BP 90/60, temperature was 100°F. She was dehydrated. Abdominal examination revealed an irregular mass in right lower abdomen, and it encroached upon the suprapubic region and reached upto the level of umbilicus. The mass was fixed and tender. The abdomen was distended and the bowel sounds increased.

The uterus was retroverted normal in size. The abdominal mass was felt separate from the uterus. Because of amenorrhoea and the abdominal findings, the provisional diagnosis of in-

testinal obstruction associated with abdominal pregnancy was made, although the possibility of pedunculated fibroid or an ovarian tumour could not be ruled out. The X-ray abdomen revealed slight fluid levels and soft tissue shadow on the right side. She was treated with intravenous fluids and antibiotics for 5 days. A week after admission, laparotomy was done and an intact gestation sac (6" x 4") was found on the right side, and the lower half of the gestation sac was covered with thick reddish placental tissue. A loop of intestine was adherent to the gestation sac at the posterior surface and this was the site of intermittent, subacute intestinal obstruction. There was no sign of fallopian tube and ovary on the right side. The uterus and left adnexa appeared normal. The sac was excised.

Case 3

Advanced abdominal pregnancy. A nulliparous, aged 30, was admitted with 10 months amenorrhoea and vague abdominal pain and vomiting for last 3 days. Her last menstrual period was unknown and her current pregnancy had been otherwise uneventful. She had undergone an abdominal operation 2 years ago and a lump had apparently been removed. The details pertaining to this operation could not be obtained.

There was a midline scar. The uterus corresponded to 34 weeks gestation. The presentation of foetus could not be well defined and the foetal heart sounds were absent. There was no tenderness. The pelvis was adequate and the presenting part was high. Haemoglobin was 7 gms%. X-ray abdomen showed a single foetus presenting as vertex and showing signs of intra-uterine death. She was given imferon injections for anaemia.

In view of retained dead foetus, syntocinon was started. The initial dose of 5 units gradually increased to 40 units on 4th day, failed to initiate labour. At this stage, the possibility of abdominal pregnancy came into mind, and lateral X-ray abdomen was obtained which was however inconclusive.

Examination under anaesthesia revealed a closed cervix and a slightly bulky uterus palpable posteriorly, and to the right. The presenting part was not within the reach of the examining fingers. The diagnosis of abdominal pregnancy was thus confirmed and laparotomy performed.

The parietal peritoneum appeared yellowish and was firmly adherent to the infarcted placenta underneath, which presented at the wound. Approximately 200-300 ml. of brownish fluid was aspirated from the peritoneal cavity. While gently separating the placenta on the left, amniotic sac came into view and 100-150 ml. of brownish fluid was removed after incising the sac. A macerated female foetus, 2½ Kg. weight, was extracted. The infarcted fibrous placenta was digitally separated and removed. The tags of placental tissue attached to the upper pole of the gestation sac was left in situ, so as to avoid damage to the intestines. The gestation sac was reinforced by a pseudosac and therefore the intestines, uterus and its appendages could not be visualised.

Three months postoperatively, hysterosalpingogram showed a slightly elevated uterus and both patent fallopian tubes.

Case 4

Uterine Pregnancy Superimposed on Abdominal Pregnancy (J.P.N. Hospital). A nulliparous, aged 20, gave a history of amenorrhoea and vague abdominal pain of 2 years duration. Her pregnancy had apparently progressed well to term, when she got labour pains. The pains however subsided few hours later and soon she stopped feeling the foetal movements. Thereafter, she noticed progressive decrease in abdominal girth.

An irregular fixed mass reaching upto the umbilicus was felt on the right lower abdomen. There was another cystic soft swelling palpable in left iliac fossa, and it reached upto 2-3" below the umbilicus. The cervix was pushed high up and uterus could not be defined well. The lower pole of the right mass was felt in right fornix.

X-ray abdomen revealed a single dead foetus lying curled high up on the right side, thus confirming the clinical suspicion of abdominal pregnancy. Hysterosalpingogram showed a filling defect in the uterus and a dead foetus outside the uterus.

At laparotomy, a gravid uterus of 14-16 weeks size was pushed to the left. On the right side, a gestation sac (8-9") was seen occupying and partly burrowing into the right broad ligament. There were intestinal adhesions both on the anterior and posterior surface of the gestation sac. The round ligament was stretched over the sac but the fallopian tube and ovary could

not be identified. During the dissection of the sac the ureter was found densely adherent to its posterior aspect. Further dissection was abandoned, the sac was incised and a macerated foetus delivered. There was no liquor amnii. The infarcted placenta attached to the lower surface of the gestation sac was removed except a small portion in the vicinity of the ureter. The broad ligament was closed with continuous catgut sutures, and the abdomen closed without a drainage.

Her antenatal period thereafter was satisfactory until she had a premature breech delivery at 34 weeks. A female weighing 2 Kg. died few minutes after birth. She had a flexion deformity of right hand and right foot. Post-mortem was refused.

Discussion

In 8 years' period, the incidence of abdominal pregnancy in Simla was 1:1653 deliveries. In Maulana Azad Medical College, New Delhi, the incidence was 1:9216 deliveries.

Various authors have quoted 4-7.5% of all ectopic pregnancies advancing to abdominal pregnancy. Phillip (1969) as well as Jacob and Bhargava observed 1.5% of all ectopic pregnancies encountered were advanced. In the present series, the incidence of ectopic pregnancy was 1:209 of all deliveries, and that of abdominal pregnancy was 2.3% of all ectopic pregnancies.

It appears that in cities where hospital facilities are within the reach of the city dwellers, the first symptom of abdominal pain brings them to the hospital for prompt treatment of ectopic pregnancy. In hilly areas like Simla, where the transport is a problem, and a hospital not within the reach, the patients resort to rest and in some, the condition may progress to abdominal pregnancy. It may be interesting to study the incidence of abdominal pregnancy in relation to various demographic conditions in India. It is not proved that pelvic infection and

ectopic pregnancies are more prevalent in Himachal Pradesh than in other states.

All the above cases followed tubal pregnancy. Case 2 was an advanced tubal pregnancy, and Case 3 appears to be a fimbrial pregnancy, similar to that described by Phillips (1969). A compound variety of abdominal pregnancy (Case 4) with the superimposed uterine pregnancy is very rare. Gulati and Jain (1975) quoted an incidence of combined variety as 1:24833 of all pregnancies.

Three of our cases were nulliparous. Raju and Reddy (1962) also observed that 75% of their cases were either nulliparous or 2nd gravidas.

Case 1 presented as uterine fibroids, and a similar case has been described by Naidu. Case 2 was admitted primarily for recurrent intestinal obstruction, and case 4 with prolonged amenorrhoea.

In Hreschyshyn, *et al* (1961) series of 101 cases, only 43% were diagnosed pre-operatively. The present study shows that case 2 and 4 were clinically diagnosed. Case 3 was diagnosed only after failure with prolonged syntocinon drip.

X-ray abdomen is useful if the foetus is a lithopaedion, (Case 1) or occupies a very abnormal position (Case 4). Lateral X-ray abdomen is not always conclusive (Case 3). Hysterosalpingogram is confirmative, but Greenhill (1965) has cautioned against its indiscriminate use. It was surprising that case 4 continued her pregnancy to 34 weeks despite an early interference by hysterosalpingogram. Syntocinon drip as suggested by Cross (1951) and Subhadra Devi (1971) aided in the reappraisal of diagnosis in Case 3.

Laparotomy should follow the diagnosis, and the waiting policy for the foetus to mature is not justified. The catastrophic haemorrhage can also occur

during this waiting period. The post-operative methotrexate in half the dose as suggested by Hreschyshyn et al (1961) to hasten placental resorption may be worth considering if placenta can not be removed. The placenta however does get absorbed eventually as recorded by Raju and Reddy (1962) and also seen in case 1 under study.

The operative injuries to bowel and ureter are not uncommon as seen in case 1 and also described by Subhadra Devi (1971).

The perinatal mortality is so high and foetal malformations so frequent that one should always safeguard the mother's interest in the management of abdominal pregnancy.

References

1. Cross, J. B.: Am. J. Obstet. & Gynec. 62: 303, 1951.
2. Greenhill, J. P. (1965): Obstetrics, 13th edition, 560, W. B. Saunders Company, Philadelphia and London.
3. Gulati, B. and Jain, A.: J. Obstet. Gynaec. India, 25: 414, 1975.
4. Hreshchyshyn, M. M., Ben, B. and Loughran, C. H.: Am. J. Obstet. & Gynec. 81: 302, 1961.
5. Jacob, S. I. and Bhargava, H.: J. Obstet. & Gynaec. India, 19: 646, 1969.
6. Naidu, P.: J. Obstet. & Gynaec. Brit. C'wealth. 67: 843, 1960.
7. Phillips, C. and Kaur, G.: J. Obstet. & Gynaec. India, 19: 109, 1969.
8. Raju, R. G., Reddy, R. S. and Savitri, C.: J. Obstet. & Gynaec. India, 12: 560, 1962.
9. Subhadra Devi, N.: J. Obstet. & Gynaec. India, 21: 400, 1971.