HYDRAMNIOS IN A CASE OF FULL TERM ABDOMINAL PREGNANCY

by

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Summary

A case of full term abdominal pregnancy associated with hydramnios has been described. Source of liquor amnii has also been described.

Jeffcoate (1969) has stated that in abdominal pregnancy, liquor amnii is usually scanty. He thinks that when amnion is intact, the maternal contribution via decidua is missing. But in this case, severe hydramnios was observed and this is very rare. It is worthwhile to present the case because of extreme rarity.

Case Report

Mrs. K., a Moslem woman aged 25 years was admitted into the General Hospital, Sokoto, Nigeria on 23rd August, 1975 as a referred case on account of prolonged pregnancy, huge distension of abdomen, dyspnoea, abdominal pain and backache. She had extreme weakness, great loss of weight and loss of foetal movement for last 2 months.

History of Present Pregnancy: Although she was not sure of her last menstrual period, she thought that present pregnancy was overdue by 2 months. Throughout the present pregnancy, she was not well at all. During the early month of pregnancy, she had severe abdominal pain and dizziness for which she was hospitalised in a divisional hospital. She got better with treatment, but abdominal pain, nausea, dizzines and intermittent vaginal bleeding persisted. Her abdomen was unduly enlarged when pregnancy progressed to 6 months. Since then her abdomen grew bigger and bigger as to make her completely invalid and stay in bed. She became breathless at rest.

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Obstetric History: Para 2 + 0, last child birth 3 years back.

Past History: Nothing significant.

General Examination: She was pale and extremely emaciated. Dyspnoea was moderate and there was oedema of legs.

B.P. 100/60, pulse is 120/mt. There was no cyanosis.

Heart and Lung: No abnormality detected.

Abdomen: Marked distension was present. Girth of abdomen was 58″. Abdominal wall was oedematous, shinny and full of veins. Fluid thrill was prsent everywhere. Abdomen was tense and tender and it was difficult to feel anything except a ballotable mass in the right hypochondriac region. Percussion was dull. F.H.S. not heard.

Vaginal Examination: Vulva and vagina were normal. Cervix was tightly closed and non-pregnant. Fornices were full and foetal parts were not felt. Uterus could not be identified. Brownish vaginal discharge was present.

Investigations: Hb—50% urine N.A.D.

X-ray: A mature foetus was presenting by breech. Spalding's sign was present. With pitocin drip, no uterine contraction could be elicited.

Diagnosis: Advanced extrauterine pregnancy with hydramnios.

General condition of the patient was improved by blood transfusion intramascular iron, folic acid, vitamins and amniocentesis (400 cc greenish liquor). Laparotomy was done on 24th September, 1977. Peritoneum and the gestation sac were opened together and 5000 cc of liquor amnii drained out. The baby was delivered as breech. The scalp of the baby was adherent to the top of the gestation sac. During the extraction of the baby, a portion of hairy scalp was left in the sac as it could not be removed. The gestation sac shut off completely, the intestine and other organs in peritoneal cavity. The placenta was found to be attached to pelvic cavity. Uterus and other pelvic organs were not seen. It was realised that attempt to re-

move the placenta would not be safe, so the cord was cut close to placenta and the abdomen was closed leaving a drainage tube in the sac.

Baby was male (weighing 6 lb.) macerated and oedematous. A No. 9 catheter was passed through its mouth and obstruction was met at 9 cm. from its mouth. Oesophageal atresia was suspected. No other congenital abnormality was present.

Postoperative period was stormy. The drainage tube was inadvertently removed while the dressing was changed and it could not be put back. Surprisingly the incisional wound healed quickly and she developed a swelling in lower abdomen on 10th day of operation associated with pain and hectic fever. The cystic mass was incised and one pint of brownish pus was drained. She got better but a sinus developed near the umbilicus discharging a little offensive pus. It was deep. But before further investigation, she had to go home for certain family reason. Vaginal examination revealed a diffuse mass in the pelvis. Uterus seemed to be incorporated in the mass. The patient came back to the hospital after one year with the old sinus near the umbilicus discharging pus. Sinogram revealed a long sinus reaching possibly to the peritoneal cavity with accumulation of dye in diffuse manner at the button of the sinus.

Exploration of the sinus revealed the connection of the sinus to the peritoneal cavity where omentum was enclosing a hairy mass. A portion of placenta calcified was found adherent to the fundus of the uterus, the left tube and broad ligament. The right tube and ovary were healthy. The placenta was removed by excising the disorganished left tube, a portion of broad ligament and superfecial part of the fundus of the uterus. The hairy mass and a portion of omentum were removed. The patient made an uneventful recovery and went home on 7th day after operation.

Discussion

It is obvious that it was a case of secondary abdominal pregnancy from the left tube. She had a sudden attack of severe abdominal pain necessitating hospitalisation in the early month of pregnancy indicated intraperitoneal catastrophy possibly dislodgment of ovum and haemorrhage in peritoneal cavity.

Oligoamnios is common in abdominal pregnancy because decidua is missing. (Jaffcoate 1969). Scanty liquor is responsible for foetal diformities such as talepes. Adhesion of the foetal scalp to amniotic sac in this case suggests scanty liquor amnii at early months of pregnancy. But later on quantity of liquor amnii increased to enormous extent. In this case, mother had hardly any contribution to the formation of liquor because decidual vessel through which the transduation takes place were absent. Liquor amnii in this case is most likely to be foetal in origin and is a transduation of foetal vessels and placenta. Foetal urine also contributes to it. Absorption of liquor amnii takes place from respiratory tract and gut of the foetus and also through amnios into the mother. In this case absorption through amnion was poor since there were no decidual vessels. Secondly the baby could not swallow liquor due to atresia of sesophaus. These two factors were responssible for hydramnios in this case. It is always safe to remove long dead placenta. They believe that abdomen should be completely closed and marsupialisation and drainage should not be done. But this case proved conclusively that drainage of the gestation sac is very important. Another conclusion to be drawn from this case is that mother plays little role to the contribution of liquor amnii.

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References

1. Jeffcoate, T. N. A. (1969): Principles of Gynaecology: IIIrd Edition, Page 279.

See Figs. on Art Paper IV