SECONDARY ABDOMINAL PREGNANCY

(Report of 5 Cases)

by

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Five cases of abdominal pregnancy along with twin abdominal pregnancy had been admitted to our ward of the Patna Medical College Hospital in the last 5 years. To our knowledge, no case of twins in a abdominal pregnancy has been reported so far.

The picture varied in all cases and diagnosis was not always immediate.

Case 1

Smt. U.D. aged 30 years, 3rd gravida was brought on 10th March 1977 at 12 a.m. in a very low general condition. She had not passed urine for the last 20 hours. Abdominal distension was well marked and she was in great agony. Seven years ago her first pregnancy terminated in still birth at term while second baby was alive and 5 years old. Dilatation and curettage was performed on her as a treatment for secondary infertility in a small hospital 1 year ago. Her menstrual cycles were normal.

Two months ago she was diagnosed as a case of threatened abortion of 16 weeks and she continued the treatment till date. Vague pain in the abdomen persisted. Suddenly one evening she developed acute abdominal pain associated with vomiting and syncope and was brought to emergency section of the hospital.

On examination she looked very pale. Her pulse was 130-140/mt., B.P. 90/60 m.m. of Hg. There was marked distension of abdomen with no bowel sounds. The bladder was full. Vaginal examination was inconclusive. A provisional diagnosis of ruptured uterus was made and laparotomy performed. On laparotomy the peritoneal cavity was full of fluid blood about 1000 ml. A dead foetus of about 24 weeks size was within a sac and placenta was found to be attached onto the omentum. On the uterine fundus one old rent of about one cm. more toward the left side was seen through which a finger could pass. The foetus and placenta were removed and repair of ruptured fundus was done in two layers. Primary pregnancy appeared to be in the uterus only which later on extruded into the peritoneal cavity. Her postoperative period was uneventful.

Case 2

On 8th May, 1977 Mrs. H. K., primi of 20 years was admitted with history of 5 months amenorrhoea with pain in the abdomen and vaginal bleeding for 1½ months. The pain and bleeding increased for last two days. She did not remember her last menstrual period correctly.

On examination, the patient was severely anaemic with pulse 100-120/mt., generalised tenderness and distension was the only positive finding. On abdominal examination foetal parts or uterine outline could not be felt. On pelvic examination uterus of 18-20 weeks deviated to right side was felt with slight blood stained discharge. No other mass could be felt vaginally.

Immediate laparotomy was performed for ruptured uterus. In the peritoneal cavity 2 dead foetuses in 2 different sacs were seen. The peritoneal cavity was full of fluid and blood. There was only one placenta which

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was partly attached to uterine fundus and partly to the mesentry and omentum. Omentum was also attached to the uterine fundus. On clearing the adherent omentum from fundus, a rent of about 1½ cms. was seen posteriorly. The placenta was large and spread over a large area. It was removed partially and also a piece of adherent omentum was removed. The torn fundus was repaired. She left hospital on 14th postoperative day with Hb 12 gms. She established her menstrual cycles two months later. No history of any previous operation could be elicited but terminations are rarely confessed by the patients, specially in this state.

Case 3

On 10th July, 1977 Mrs. R.I. 3rd gravida, 30 years old came with history of amenorrhoea of 9 months and cessation of foetal movement for the last 10-15 days. She had no previous antenatal checking done.

On examination she was moderately anaemic. Her pulse was 90/mt., B.P. 120/70 mm of Hg. abdominal examination of uterus felt about term size with an oblique lie, head being in the left iliac fossa. Foetal heart sounds could not be located. A diagnosis of intrauterine foetal death was made.

Plain X-ray of abdomen showing 'flying' foetus suggested the possibility of abdominal pregnancy. Uterine sound was passed and diagnosis was confirmed. Hysterography could not be done due to vaginal bleeding. Laparotomy was planned but the patient left the hospital as she did not agree for any surgical interference.

She was admitted on 5th August in a very low condition with signs of internal haemorrhage and abdominal distension. Immediately laparotomy was performed on her after all rescustative measures.

On opening the peritoneal cavity a dead macerated female foetus with partially autolysed placenta was seen. Pus was also present in the peritoneal cavity which was sent for culture and sensitivity There were multiple adhesions. Uterus, tubes and ovaries were hardly recognised. Dead foetus was removed. Placenta was seen attached to the mesentry and was left in situ. An abdominal drainage tube was put for 48 hours.

The patient went into septic shock which was controlled with very high dose of Cortisone and Ampicillin injections and Tetracycline. Later the antibiotic was changed to Garamycin. Moreover, she required secondary sutures as the wound failed to heal due to severe infection

Case 4

Mrs. L. D., Primi, came to the outpatient department on 10th Feb. 1977 with a history of 10 months amenorrhoea, pain in the abdomen and cessation of foetal movements for the past 1 week, with no previous antenatal check up. She did not remember the date of last menstrual period correctly.

On examination, the patient was in good general condition. Height of the fundus was four fingers above umbilicus. Foetus was placed obliquely with head in the left iliac fossa. No foetal heart sounds were heard. Mild abdominal distension was noticed. On vaginal examination, uterus could not be felt separately, cervix was soft three fourth of an inch long and closed. She was diagnosed as a case of intrauterine death of foetus because of postmaturity. Bleeding and clotting time were found to be within normal limits.

X'ray showed Spalding sign but no clear position of foetus. Therefore it was planned to terminate the pregnancy with syntocinon in rising doses, starting from 5 units in 5 per cent glucose. The concentration was gradually increased to 50 units in one pint of glucose for one week without any effect. This made us to revise our diagnosis and suspicion of abdominal pregnancy arose. Uterine sound was passed upto 6" without resistence and hence no conclusion could be drawn.

On opening the abdomen a dead macerated female foetus of almost term size was seen lying in a sac in the peritoneal cavity. Placenta was attached to omentum and mesentry. Dead foetus was removed and also the placenta could be trimmed off a little along with omentum. Here also a small rent in the posterior aspect of fundus was seen which was repaired in two layers. It was evident that foetus in early stage with placenta had extruded out in the peritoneal cavity. Both tubes and ovaries were healthy.

Case 5

On Feb. 1978 M.D. came to the emergency with abdominal distension, full bladder with history of 9 months amenorrhoea. She was

dehydrated, had rapid pulse and low B.P. 100/68 mm of Hg. She was diagnosed as a case of obstructed labour with impending rupture of uterus. Hence, after resuscitation and fluid electrolyte replacement, immediate laparotomy was planned.

On opening the abdomen, the thick tough pregnancy sac was mistaken for the pregnant uterus. Uncontrollable haemorrhage started as attempts to cut the sac was made. Inspite of all efforts for haemostasis and resuscitation, the patient could not be saved. The site of primary pregnancy could not be made out due to adhesions all round and low condition of the patient.

Comments

The unusual features in the 3 cases out of 5 was that the primary site was uterus itself, and gradual rupture took place with expulsion of foetus and implantation of placenta over the uterus and omentum. In case 1 the fundus was torn and lying open with the patient complaining of vaginal discharge and bleeding. The cause of rupture could be uterine perforation at the time of curettage and subsequent implantation of placenta at the site of perforation. The other 2 cases with uterine rent gave no obvious history of any injury or operation. However, possibility of termination or illegal pregnancy by untrained personnel cannot be excluded. In cases 3 and 5 site of primary pregnancy could not be ascertained.

Abdominal pain and tenderness seem to be constant features. False thick capsule over the amniotic sac made the diagnosis quite difficult in case 5. In case 4, syntocinon drip was started for three consecutive days presuming it to be case of intrauterine death of foetus. Sudden shock and a state of acute abdomen met in cases 1 and 2 may be due to internal haemorrhage inside caused by sudden erosion of mesentric vessels due to separation of placenta or displacement of intestine. Diagnosis is often confused with ruptured uterus or other acute conditions. High, loose hanging cervix is a significant finding in such cases.

Hysterography can be very helpful but can only be done after uterine pregnancy is well excluded and is more or less of academic interest only. However, possibility of abdominal pregnancy should be kept in mind whenever there are vague symptoms, pain, tenderness with I.U.D. or abnormal position and lie of the foetus. Normal size of the uterus as tested by passing the sound along with presence of foetus in the abdomen is conclusive but occasionally the sound may pass through the rent and may be mistaken for uterine pregnancy. Laparotomy with an adequate supply of blood should be done as early as possible. Care has to be taken even during the abdominal incision to avoid injury to placenta or blood vessels. The sac must be opened at its least avascular area. Case 5 shows the unfortunate result where this caution was not observed.

Placenta was kept in situ in case 2 and was partially removed in 2 cases. The follow up of these cases did not show any significant difference. Their postoperative recovery was smooth and laparotomy for removal of placenta at a later stage was not required.

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