ADVANCED SECONDARY ABDOMINAL PREGNANCY

(Report of 5 Cases)

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Because of the problems in diagnosis, management, associated high foetal and maternal mortality, abdominal pregnancy remains a very important condition and the rarity of the condition prompted us to report the following 5 cases seen at Medical College Hospital, Rohtak, Haryana during a 7-year period (Dec. 1971-Jan. 1978).

Case 1:

Mrs. B. 38 years, P 3 + 1, G5 was admitted as emergency on 27th May, 1977 with history of 41 weeks amenorrhoea and loss of foetal movements for 4 days. She had no history of pain in abdomen, vomiting or vaginal bleeding. She had 3 full term normal deliveries and last pregnancy terminated at 3 months spontaneously 3 years ago.

On examination. General condition was good. Transverse lie with head in left lumbar region was palpated, F.H.S. absent. Cervix admitted 1 finger. Uterus was 12-14 weeks in size. Uterine cavity felt empty. Diagnosis of rupture uterus was made and laparotomy decided.

At laparotomy, uterus was 12-14 weeks, Gestational sac was lying in the periotenal cavity and after opening it macerated female baby removed. Placenta was found to be attached to right tube and right accessory rudimentary horn of uterus. Placenta was removed completely and total hysterectomy alongwith right salpingo-oophorectomy was done. Postoperative period was uneventful and she was discharged on 14th post-operative day. Primary site of gestation was right accessory horn.

Case No. 2:

Mrs. S., 20 years old P 1 + 0: G2 was admitted on 4th July, 1977 with 39 weeks amenorrhoea along with continuous pain in abdomen and fever for 7 days. She had vomiting in first trimester. There was no history of vaginal bleeding. She had one premature delivery of 7½ months gestation 2½ years ago.

General condition was good. On abdominal palpation. Definite uterine outline could not be made out. Foetus was lying transversely in the abdomen with head in left lumbar region. FHS could not be heard. Cervix admitted one finger. Uterus 12-14 weeks in size and elevated. !Uterine cavity felt empty. Provisional diagnosis of secondary abdominal pregnancy was made and laparotomy decided.

At laparotomy, peritoneum was found to be thickened and on opening the peritoneal cavity, gestational sac got opened and an alive female baby weighing 3.2 kgm extracted. There were no congenital anomalies in the baby but it was asphyxiated and died 4 hours later. Placenta was attached to omentum as well as ruptured left accessory horn. Left tube was attached to accessory horn. Placenta was removed completely alongwith left tube and left accessory horn. Post-operatively patient had pyrexia on 3-4 occasions and was discharged on 24th day in good condition. Primary site of gestation was left accessory horn of uterus.

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Case 3:

Mrs. M, 30 years P4 + 0, G5 was admitted as emergency on 15th October, 1973 at 12.45 P.M. with 35 weeks amenorrhoea. She was having pains for 8 hours and vaginal bleeding for 2 hours prior to admission. She had 4 full term deliveries, the last child birth was 1 year ago by Caeserian section. There was no history of bleeding, pain or painful foetal movements during the present pregnancy.

General condition was poor. Hb. was 6.5 gm%. Pulse feeble. BP not recordable. Pallor present. Abdominal examination revealed superficial foetal parts. FHS absent. Pelvic examination—Cervix 2 finger loose. Uterine outline not made out. Bleeding through os present. Diagnosis of rupture uterus of previous Caeserian section scar was made and laparotomy done.

On opening the abdomen, baby with sac was found to be in the peritoneal cavity. Dead female baby was removed. There was rupture of previous classical Caeserian section scar and placenta was found to be attached to the margins of uterine scar as well as omentum. Placenta removed completely and subtotal hysterectomy was done. Patient had to be given 4 units of blood. She had uneventful postoperative period and was discharged on 9th day.

Case 4:

Mrs. Sh. 21 years P 1 + 0, G2 was admitted as emergency on 23rd December, 1971 with amenorrhoea for 41 weeks along with rapid increase in the size of abdomen for 4 days. She denied any history of pain in abdomen, discomfort or vaginal bleeding at any time during the present pregnancy. She had 1 full term normal delivery 1 year ago.

General condition was fair. Abdominal findings were consistent with full term pregnancy. Head was felt in right lumbar region with difficulty. FHS present. Ascites present. Cx long, not effaced and admitted 1 finger; Uterus 18-20 weeks size. Diagnosis of pregnancy with ovarian cyst was made and patient was subjected to laparotomy.

At laparotomy, there was free fluid in the peritoneal cavity. There was no amniotic cavity and foetus was found lying transversely in abdomen. There were bands of adhesions between foetal limbs and the gestational sac, which was attached to the intestines and over to the uterus. Alive female baby weighing 6 lbs delivered after incising the bands. Baby was resusciated with difficulty and expired 16 hours later. Whole of placenta could be removed in picemeal.

Case 5:

Patient T.W. aged 30 years, P 2 + 0, G3 was admitted on 9th January, 1978; with history of amenorrhoea for 39 weeks and loss of foetal movements for 4 weeks. She had 2 full term normal deliveries last child birth being 10 years ago.

During the present pregnancy patient was admitted earlier in this hospital on 25th June, 1977 with history of 2 months amenorrhoea and bleeding per vaginum for 1 day. She had no vomiting or pain abdomen at that time. Pelvic examination by resident at that time revealed uterus 10 weeks size. Diagnosis of threatened abortion was made and conservative treatment was given. She was discharged after 10 days as bleeding stopped. One month later, she had pain in lower abdomen alongwith episodes of fainting. Thereafter throughout her pregnancy she did not have any discomfort, pain abdomen or bleeding per vaginum. However, she had no antenatal check up.

General condition was good. Uterus was 26-28 weeks size of pregnancy. Foetal parts were felt with difficulty although cephalic presentation could be made out. FHS absent.

A diagnosis of intrauterine foetal death was made and syntocinon drip was started. She did not get any uterine contractions inspite of oxytocic drip on 4 occasions. Hypertonic saline (20%), 150 cc was put in gestational sac to which she did not respond either. Insertion of laminaria tents was considered on 24th Jan. 1978; when a repeat pelvic examination was made, uterus was found to be 8 weeks size, separate from the abdominal mass. At laparotomy, peritoneum was adherent to gestational sac. Right ovary, tube and uterus were normal. Cornual end of left tube was visualized but rest of the left tube and left ovary seemed to be incorporated in the gestational sac.

Macerated female baby weighing 2.25 kgm with talipus deformity of both feet extracted. Placenta was attached to small intestines, omentum, left tube, left ovary and was removed completely and left salpingo-oophorectomy was done. Right tubectomy was done by modified Pomeroy's technique.

Patient had smooth convalescence except for slight purulent discharge from abdominal wound and was discharged in good condition. Left tube was the primary site of gestation.

Discussion

Only 2 out of 5 cases reported could be diaggnosed preoperatively, 2 being mistaken for rupture uterus and 1 for pregnancy with ovarian cyst.

All our patients were in advanced stage of pregnancy between 35 and 41 weeks. Surprisingly none of our patients had any discomfort, pain in abdomen or painful foetal movements during pregnancy although 1 patient had pain and bleeding in the first trimester.

Placenta could be removed completely in all of our cases although in addition hysterectomy had to be done in two cases, salpingo-oopherectomy in one and excision of accessory horn alongwith salpingectomy in one patient. All our patients were discharged in good condition.

Summary

Five cases of advanced secondary abdominal pregnancy between 35-43 weeks are reported. Two babies were born alive. All were females. One liveborn baby had congenital bands around limbs. Two cases were diagnosed preoperatively. Placenta was removed in all the cases completely. The present day trends in management of abdominal pregnancy are discussed.