ADVANCED ABDOMINAL PREGNANCY

(A Case Report)

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Introduction

Abdominal Pregnancy is a rare occurrence, the incidence recorded being 1 in 2841 (Dutta, D.C., 1978) to 1 in 31,281 deliveries (Oumachigui, *et al*, 1978). It is still very rare to reach term or near term and deliver a living infant. And, primary abdominal pregnancy is still rarer (Masani and Parikh, 1976), thus prompting us to report this case. This is the only case we have come across during the last 17 years among 29,526 deliveries in the hospital.

CASE REPORT

Mrs. B. D., 36 years, gravida 4 with 2 living children was admitted on 10-8-77 at her 8th month of pregnancy with the complaint of acute abdominal pain specially on the left side of abdomen for last 7 days. Her menstrual history was irregular with L.M.P. probably in January, 1977 making her expected date of delivery in October, 1977. No other relevant history could be elicited. During the present pregnancy, she had vague abdominal pain off and on for about 3 months which was treated by a local doctor and relieved. In her last delivery, she had moderately severe post partum haemorrhage. She did not have any operation in the past.

Clinical Findings

The patient was emaciated, anaemic without jaundice; pulse 90/min. B.P. 100/60 mm of Hg. Other systems were within normal limit. Abdominal examination revealed 32 to 34 weeks pregnancy with unusual superficial foetal parts lying transversly. The foetal head was fixed in the lower flank with distinct F.H.S. and normal rate. A firm lump felt in the suprapubic region slightly more on the right side arising from the pelvis, extending to about 10-12cm. above the pubis. Vaginal examination revealed all the signs of pregnancy. The cervix and uterus was felt continuous with the suprapubic mass but the foetus was felt separately. A provisional diagnosis of abdominal pregnancy was made.

Investigation

Her Hb. was 8.0 G%, ESR. 70mm first hour (Westergreen) and platelet count of 1.8 lacs/cmm of blood. Serum electrolytes were within normal limit. Urine showed a trace of protein and sugar. X-ray abdomen P.A. and lateral views (Fig. 1-A & B) showed a transverse lie

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of the foetus with absence of uterine shadow and presence of foetal parts overlapping the vatebrae. No further investigation could be done because of her condition which demanded immediate emergency operation.

Management

An emergency laparotomy was performed on 4-9-77. On opening the abdomen, the amniotic sac was seen through the opening and the peritoneum was found free from any fluid or haemorrage. On rupturing the sac, fibrous bands (amniotic) were seen around the body of the baby anchoring to the sac wall and placental margin. After cutting the bands, a living baby was delivered. The placenta was found attached to the fundus on the right supero-posterior surface of the uterus. Uterus was enlarged to about 8 weeks size. The tubes, ovaries and the remaining external surface of the uterus were normal, healthy and free. No sign of past pelvic pathology was present. Subtotal hysterectomy was completed along with the attached placenta intact. The post operative period was uneventful.

Baby:

Female, Wt. 2.75 kg., Apgar Score 7/10 but though cyanosed, resuscitated easily. Constrictions about 2cm. were present around both upper arms connecting with that of trunk constriction and the anterior and posterior axillary folds on both sides were fused loosely. Another wide circumferential constriction was seen around the trunk at 1 and 2 L vertebrae level and also at the upper part of the thighs (Fig. 2-A, B & C) connecting to that of trunk. The baby died on the third day of delivery because of R.D.S. No postmortem examination could be followed as the parents objected to such procedure.

Pathological Findings of the Hysterectomy Specimen:

A globular partially opened up uterus 6 x 6 x 4cm. with thickness 1.5cm. at its lower and with a discoid placenta 12 x 10 x 5.5cm. sitting over the fundus received (Fig. 3-A). A piece of cord 45 cm. was attached to one side of the placenta. The uterine lumen was slightly dilated and showed an elongated greyish firm mass approx. 3.3cm. long hanging in the cavity. At the site of placental attachment, the uterine myometrium was very much thinned out leaving a thin shell adjacent to the cavity (Fig. 3-B). Microscopic examination of the thin shell of myometrium underlying the placenta showed the myometrium to be devoid of decidua or trophoblastic villi. The elongated mass in the uterine cavity was decidual tissue (decidual cast) without any chorionic villi (Fig. 4). The uterine endometrium was in proliferative phase.

Discussion

In this case, diagnosis was not difficult but the suprapubic mass was considered to be a degenerating fibroid or a twisted and fixed ovarian cyst, prior to laparotomy. We took risk in allowing to prolong the pregnancy for maturity under strict observation balancing her general condition and intensive conservative treatment. We decided subtotal hysterectomy because of the firm and extensive attachment of the placenta to the uterine fundus and patient's desire to undergo ligation operation to avoid further pregnancies as well as the general condition of the patient during that emergency procedure. Decidua was found sloughed in one piece in the uterine cavity in this case, perhaps during a spurious labour. Findings at laparotomy and the absence of uteroperitoneal fistula and presence of a decidual cast, a completely extra-uterine placenta and normal tubes and ovaries, suggest this case to be a case of primary abdominal pregnancy. Whether there was already a thinned and weakened spot in the uterine wall and the trophoblastic villi gradually grew outward through the weakened spot bringing ultimately the entire placenta outside is difficult to ascertain as there was no history of previous uterine operation or trauma or rupture of uterus in this case.

Summary

A case of advanced abdominal pregnancy, possibly primary with delivery of

a living foetus has been reported. Available literature reviewed and discussed.

Acknowledgement

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See Figs. on Art Paper XI-XII