RECURRENT ABDOMINAL PREGNANCY

(A Case Report)

by

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Introduction

Abdominal pregnancy is rare and incidence of abdominal pregnancy is 1 in 2559 full term delivery Mukherjee and Mukherjee (1976) and 1 in 21,6000 by Kharan and Shah (1976) in India. A recurrent abdominal pregnancy is very rare and is being presented.

CASE REPORT

A Hindu female, 27 years, gravida II para I was admitted in December 1980 for loss of fetal movements and slight vaginal bleeding for last 1 week with no previous antenatal check up. Her previous menstrual cycles were regular, her last menstrual period was 8th March, 80. She had no complaints in early months of pregnancy. Regarding her past obstetric history her first pegnancy was after one year of marriage and she had similar complaints at 8th months of pregnancy. She was ultimately opened up and advanced abdominal pregnancy was found and a macerated male baby was delivered. The placenta was left in situ. The patient had severe post operative infection and was discharged after one month.

On examination, the patient was slightly anaemic, her B.P. was 120/80 mm Hg, pulse 80/minute. Abdominal examination revealed 34 weeks gestation, foetal parts could not be clearly palpable. Braxton Hicks contractions and external ballotment were absent. F.H.S. could not be heard. On vaginal examination cervix was not soft, long and was pushed behind the symphysis pubis. Body of the uterus felt anterior. Posterior fornix was full and hard bony parts could be felt. A provisional diagnosis of abdominal pregnancy was made.

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Her Hb. was 8 gm%, B.T. and C.T. were within normal limits. Plain X'ray abdomen showed spalding's sign with hyperflexion of spine and foetal bones overlapping the maternal spine (Fig. 1). Oxytocin sensitivity test was negative. A lateral X'ray of abdomen and pelvis with a sound in uterine cavity showed uterine sound away from the presenting part of the foetus, confirming the case to be abdominal pregnancy with death of foetus (Fig. 2). On the next day the patient developed features of general peritonitis and toxaemia. The patient was kept on conservative therapy with garamycin and I.V. iluids and emergency laporatomy was performed after 48 hours. There was much difficulty in getting access to the peritoneal cavity. During separation of adhesion, foul smelling pus-like putrid material and a putrified male foetus of 32 weeks gestation was removed from the peritoneal cavity. Uterus was 10-12 weeks size gestation and there was an old rent in posterior wall of the body of the uterus. (Fig. 3). Putrified placenta was partly adherent to the posterior wall of uterus and partly to the omentum. The placenta was removed piece meal and there was no bleeding. As there was a large rent in the posterior wall and an infected uterus, subtotal hysterectomy was performed. The post operative period was uneventful and the patient was discharged on 8th pos operative day.

References:

1. Kharam, W. and Shah, A.: J. Obstet. Gynaec. India, 26: 771, 1976.
2. Mukherjee, S. and Mukherjee, N.: J. Obstet. Gynaec. India, 26: 442, 1976.