ADVANCED EXTRA UTERINE PREGNANCY—PIT FALLS IN THE DIAGNOSIS

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SUMMARY

A case of advanced extra-uterine pregnancy with a living foetus without any congenital malformation is reported. Pit falls in the diagnosis were pointed out even with the sophisticated investigations like sonar and radiological aids.

Introduction

The term abdominal pregnancy implies pregnancy within the peritonial cavity and excludes tubal, ovarian, and intra-ligamentous pregnancies. Recognition of this condition remains a problem. It is comparatively rare to come across a full term Extra Uterine Pregnancy where the foetus is alive and normal. It is obvious from the following case report that there are several pitfalls in its diagnosis which is the main purpose of reporting this case.

CASE REPORT

A 30 years old third gravida referred from Taluk Hospital on 6-9-1983 as a case of transverse lie with labour pains for caesarean section. had full term normal deliveries at home. Last child birth was 2½ years ago. She did not give give history of lower abdominal pain or vaginal bleeding in early months suggestive of tubal abortion or rupture.

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On general examination patient was of an average build, anaemic, her blood pressure was 110/70, pulse 92/mt. temp. was normal and had mild edema of the feet. Heart and lungs were clinically normal. Hb. was 65% Urine NAD.

On abdominal palpation, abdomen was over distended, Tense, not tender, Multiple foetal parts were felt, FHS was 140/mt regular but distant.

On pelvic examination: cervix was one inch long high-up, Ext. Os patulous, int. Os. was closed. A tentative diagnosis of multiple pregnancy with mild hydramnios was made. She was kept under observation, and investigated. Ultrasound scanning for confirmation of twins and congenetal malformation as well as for localisation of placenta showed a single foetus, presenting by breech and of 38 weeks maturity. The neural tube was normal and placenta in the upper uterine segment. The B.P.D. was 9.4 cm. On 8th September, patient developed acute discomfort in the abdomen.

She was restless and dyspoenic and the case was reviewed. Respiratory and cardiac problems were excluded, then the case was suspected to be an advanced secondary abdominal pregnancy since foetal parts were felt superfically and definate contour of uterus was not made out, pelvic examination showed the Cx. ½" long and high up, os admitting one finger and no foetal parts

felt through cervical os. A lateral radiograph confirmed the presentation and maturity. A shadow thought to be uterine was seen. There was neither abnormal position of foetus nor super-imposition of foetal parts over the maternal spine. On 10-9-83 patient's condition worsened, pallor increased, pulse was 140/mt. Foetal parts were felt very superfically. Diagnosis of rupture of the uterus was made and laparotomy decided.

Abdomen was opened by sub umbilical midline incision which was extended above the umbilicus. Findings were:

1. Female alive foetus lying free in the peritonal cavity.
2. Thinned out large placenta attached and adherent to amentum which was thickened and also adherent to the fundus of the uterus.
3. Right tube and ovary stretched over the placenta till the infundibulo-pelvic ligment.
4. Uterus enlarged to 14-16 weeks with flimsy adhesions between posterior surface of uterus and bowel in pounch of Douglas.
5. Left tube and ovary normal.
6. Peritonial cavity was full of old blood stained fluid.

After removing the foetus, placenta was explored removed in bits (almost entirely as placenta was attached to right tube and right ovary firmly. Right salpingo-oophorectomy was done with left side tubectomy. Abdmen was closed after identifying the ureters. Drainage tube was kept in and removed after 48 hours. Post-operative period was uneventful. Abdominal wound healed well. Patient was discharged after 20 days.

Discussion

Correct diagnosis of extra-uterine pregnancy can be made only in about 35-50% of the cases because of its rarity. The condition has to be always kept in mind wherever a case of acute abdomen in pregnancy is seen. In 1982 Delke *et al* reported 10 cases of advanced extra-uterine pregnancy, out of which pre-operative diagnosis was missed in 3 cases. If we elicit the history correctly the symptoms of earlier rutpure of ectopic pregnancy may not be available in good number of cases.. In the present case reported above, there was no history of persistant or recurrent abdominal pain which is usually a prominent symptom of advanced extra-uterine pregnancy. The reported incidence of pain was 60%. This multipara said that this particular pregnancy did not feel normal because she felt excessive and painful foetal movements. This is reported in 40% of cases. The abdominal tenderness the commonest physical finding is 100% according to Rahman *et al*, and abnormal foetal position 70%. Uterus was not felt separately in the above case. The investigations also lead us to a wrong diagnosis. Retrospectively the radiologist was consulted again. His explanation was that even the thickened omentum around the foetus can mimic the uterine shadow, which can give a false diagnosis of intra uterine pregnancy. Some times normal non-pregnant uterus could not be demonstrated due to the foetus lying anterior to the uterus. The placenta which was reported to be extending from upper uterine segment to the lower uterine segment is mistaken for placenta membranacea. The foetal parts did not lie across the maternal spine and foetus was not high-up. There was no gas shadow of maternal ileum any where near the foetal parts. Though we thought of advanced extra-uterine pregnancy the response to pitocin was not elicited as X-ray and sonar findings did not confirm the clinical diagnosis of extra-uterine pregnancy.