ADVANCE ABDOMINAL PREGNANCY

(Report of 2 cases)

by

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SUMMARY

Two cases of advanced abdominal pregnancy, one of a post-mature dead foetus and the other of infected abdominal gestation sac are presented.

Advanced abdominal pregnancy is a rare condition. More so if features of postmaturity in the foetus are present. Again although the existence of primary abdominal pregnancy is doubtful and controvertial; presence of absolutely normal uterus with two tubes and ovaries may suggest its primary origin. Here two such cases have been reported.

CASE REPORT

Case 1

D.B., 25 years, P3, was admitted on 15-6-83 for gradually increasing lower abdominal swelling with intermittent pain for last 6 months and amenorrhoea for 1½ years. There was history of morning sickness in her early months and occasional quickening. O/E, P-90/m, BP 110/70 mm. General and systemic examination revealed no abnormality. An intraabdominal hard, fixed, tender, nodular swelling occupying mainly the lower abdomen and encroaching over right upper abdomen was palpated. Uterus was normal sized and deviated to left.

X-ray abdomen showed term size foetal shadow with spalding's sign, hyperextension of spine and oblique lie.

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Hysterography showed uterine shadow was much below and separated from foetal shadow.

On 20-6-83 exploratory laparotomy was done. There were extensive adhesions underneath the parietal peritoneum and a lump could be felt on the right side. The gestational sac, was covered by tough membrane and could be separated all around from intestines and omentum and removed by blunt and sharp dissection and haemostatic transfixation sutures. The placental mass was implanted ever omentum and partial omentectomy was needed for placental removal.

The uterus, both tubes and ovaries were seen. Tubectomy and appendicetomy preceeded the abdominal closure. Blood transfusion was given.

On examination of the foetus, there were features of postmaturity, like growth of mails beyond finger tips, hard skull etc. Partial amelia of limbs and other minor congenital defects were there.

Case 2

C. B. 17 years, Po + o, was admitted in Oct. 80 as a case of acute abdomen. Patient was in shock. Her abdomen was tense, tender and destended. P/V-uterus was normal and fornices were apparantly clear.

On quadripuncture of abdomen frank pus came out. After initial resuscitation emergency exploration of abdomen was done. There was

frank pus inside the peritoneal cavity and its source was a ruptured infected gestational sac containing a termsize macerated foetus.

Placenta was implanted dangerously over great vessels and large bowel. The sac was removed and the placenta was left inside after ligating the cord close to it.

Uterus and adnaxae were apparantly normal. Abdomen !was closed after adequate toileting and leaving a drain. Patient needed extensive post-operative care to combat different complications and secondary suture of abdominal wound was required.