CASE REPORT OF A SECONDARY ABDOMINAL PREGNANCY FOLLOWING TUBOPLASTY

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Introduction

The incidence of secondary abdominal pregnancy is very low constituting 0.4% of all ectopic pregnancies. (Gorden Douglas and Stromme, 1976). Though more full term pregnancies are being reported following early diagnosis and adequate drug therapy in genital kochs in the patient who has minimal disease (Parsons and Sommers, 1978) most gynaecologist remain skeptical of reported results. They believe that chance of a pregnancy, even an ectopic one remain extremely bleak following tuberculous involvement of the genital tract. Hence the occurrence of a secondary abdominal pregnancy in a case with histopathologically documented tuberculous hydrosalpinx is a very unusual entity.

Case Report

Mrs. P.C., a 25 year old patient married for 5 years first came on 9-1-1984 with the chief complaints of primary sterility. She menstruated every 22 days but only for 1 day. She had previously undergone a laparoscopy which was reported as normal and her endometrial biopsy done premenstrually showed secretory endometrium. She suffered from grand mal epilepsy and was on 100 mg of phenytoin sodium twice a day.

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Her general examination was unremarkable but an internal examination revealed a retroverted fixed uterus, though the fornices appeared clear. All routine investigations were within normal limits and her husband's semen was also normal. An HSG revealed bilateral cornual block.

She underwent an exploratory laparotomy on 9-2-1984 which revealed a left sided cornual block with the remaining tube normal and a right sided cornual block with terminal hydrosalpinx with the ovary completely buried in adhesions.

A right sided salpingectomy was done for histology only while the ovary was not dissected out. On the left side a deep cornual anastomosis was done using an operative microscope after resecting the blocked portion of the tube.

Histopathological examination of the right tube revealed a tuberculous hydrosalpinx while the resected portion of the left tube showed a narrowed but patent tubal lumen with chronic inflammation but no tubercles.

The patient was put on isonex, refampicin and ethambutol.

On 15-9-1984 the patient came back with history of 2 months amenorrhoea with nausea and vomiting. A pregnancy test done on 3-9-1984 was reported as negative. A vaginal examination revealed an anteverted normal sized uterus without tenderness on cervical movement and no mass or tenderness in the fornices. She was given symptomatic treatment but her nausea increased. On 21-10-1984 the patient came with history of severe abdominal pain for 2-3 days and persistent nausea and vomiting. An internal examination revealed an anteverted normal sized uterus with a tender mass 8-10 cms in size in the left and posterior fornix. A ß-subunit of HCG at that stage was 300 mIU/ml (non-preg <10 mIU/ml) while ultrasonography showed "a

normal sized uterus displaced to the right with no evidence of an intrauterine gestational sac. To the left of the uterus there is a well defined echo poor area which shows fetal echoes within it. Fetal movements were present and fetal heart beats can be visualized on real time. Gestational age 16 weeks". A diagnosis of secondary abdominal pregnancy was reached.

Patient was given two courses of methotrexate of 15 mg/day for 5 days, 10 days apart (Tanaka et al, 1982; Narvekar et al, 1985) but the fetal heart beats as seen on ultrasonography persisted probably since methotrexate is effective in killing an embryo during the first 2 months of pregnancy.

Patient was then put up for exploratory laparotomy on 20-11-1984. It revealed a secondary abdominal pregnancy. The blood supply was derived from the left infundibulopelvic ligament. The sac was separated out and the vascular bundle clamped, cut and ligated. The placenta was removed along with the fetus and hemostasis was achieved. Post-operative recovery was uneventful.

References

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