RECURRENT PRIMARY ABDOMINAL PREGNANCY

(A Case Report)

By

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Introduction

The incidence of abdominal pregnancy is 1:2559 (Mukherjee *et al*, 1976). Recurrent abdominal pregnancy is still rarer, we came across only one case report (Mohanty, 1983). Hence we like to report this case of recurrent primary abdominal pregnancy.

CASE REPORT

A thin built 32 years female, unbooked, P_2+_0 was admitted in emergency in April 1986 with the complaint of pain in abdomen and slight bleeding per vaginum following amenorrhoea of 40 weeks. There was no other significant history in the past.

On general examination she was anaemic. Abdominal examination revealed a uterus corresponding to 34 weeks gestation, foetal parts were superficially palpable but the presentation could not be defined. Uterine contractions were absent and foetal heart sounds could not be heard.

On vaginal examination os was closed, cervix was tubular and uterus could not be defined properly. Dark coloured vaginal discharge was present.

A provisional diagnosis of abdominal pregnancy was made.

Her Hb was 9.5 gm%, and BT, CT were normal. Plain X-ray abdomen showed hyperflexion of spine with foetus lying in transverse position with foetal head overlapping the maternal spine. Ultrasonar supported a diagnosis of I.U.D. with Placenta praevia and not abdominal pregnancy.

Laparatomy was done and a full term dead male fetus was seen in the abdominal cavity which was removed by breech. Placenta was adherent to the pelvic peritoneum which was gently separated and removed. No rent could be demonstrated in the uterus which was of 6 weeks size.

Final diagnosis of abdominal pregnancy was confirmed on the following criterias (Studdiford's criteria). Both tubes and ovaries were intact without showing any sign of recent or remote injury. There was no uteroperitoneal communication. Presence of pregnancy was related exclusively to peritoneal surface.

Post operative period was uneventful. The same patient came in June 1987 with complaint of bleeding per vaginum and pain in abdomen following amenorrhoea of 24 weeks.

On general examination she was anaemic. On per abdomen examination uterine size was 22 weeks, no uterine contractions were felt.

On vaginal examination cervix was uneffaced tubular and os was closed. Uterus was 22 weeks size and brownish discharge was present. A provisional diagnosis of missed abortion was made.

Her Hb was 8 gm%, BT and CT was normal, ultrasonar had also diagnosed it as missed abortion.

She was given repeated oxytocin drips but no response was obtained.

A lateral X-ray view of abdomen was taken. It showed a lump in lower abdomen with overlapping on the maternal vertebral column suggestive of foetal shadow. Two units of blood was transfused and she was prepared for laparotomy.

On laparotomy there was abdominal pregnancy within the sac. The sac was adherent to the omentum and there were flimsy adhesions between the sac and the intestine which were gently separated and sac was removed with the foetus and placenta.

Both tubes and ovaries were normal. There was no area of perforation on tube or ovary.

Tubal ligation was done on request of patient. Post operative period was uneventful.

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ULTRASOUND FALSE NEGATIVE DIAGNOSIS OF ECTOPIC PREGNANCY

By

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Two cases of ectopic pregnancy where diagnosis was missed because of false negative ultrasound report and the treatment was diverted towards inflammatory pathology instead of a timely laparotomy are reported.

CASE REPORT

Case 1:

Mrs. M.A. aged 24 years had been to a practitioner on 9-5-1988 at 10.00 A.M. for pain abdomen and spotting following 3 M.A. She was a Gr. III, P. II, last child 2 years. Her cycles were regular. She did not have sterilisation for want of a 3rd child.

Clinically she was moderately anaemic and abdomen was soft with deep tenderness in left iliac fossa.

Per-vagina—uterus was bulky 6 weeks size with slight tenderness in both fornices, spotting present.

Clinical diagnosis of a threatened abortion was made and she was referred for sonography at the local area of Rajahmundry where sonogram was read by a trained doctor with 3-4 years experience with ultrasound. His opinion was — "Missed abortion and blighted ovum".

The attending doctor got convinced with the opinion of blighted ovum since he found an enlarged uterus not corresponding to gestational age.

Evacuation was done under local anaesthesia and she was discharged home the same evening.

On 21-5-1988, she was readmitted to the same hospital with history of severe in pain lower abdomen, shock like symptoms and fever of 1 day duration.

On examination patient was very pale 7 gms Hb.%, Temp. 103°F. Distension of lower abdomen, tenderness present all over. Pelvic examination—the size of uterus not exactly made out, tenderness in all the fornices.

A clinical diagnosis of pelvic peritonitis due to suspected utetrine perforation at the time of evacuation was made. Patient was treated with broadspectum antibiotics and decompression with supportive therapy including blood transfusion. She did not show any improvement.

On 23-5-88 she was referred to Government General Hospital, Kakinada for peritonitis due to probable uterine perforation.

On examination patient papery pale with 5 gms. Hb.%, pulse 140/mt, B.P. 120/84 mm of Hg. Bilateral pulmonary crepitations present.

Per abdomen distention present, rigidity and gunding of moderate degree, bewel sounds present. Pelvic examination revealed tenderness in all fornices. Uterine size not made out.

Colpocentesis done—no fluid drawn. Since she was very anaemic with pulmonary edema and hyperpyrexia she was being resuscitated with slow infusion, antibiotics and lasix.

On the next day she was evaluated. Again colpocentesis was —ve but abdominal paracentesis through the loin revealed free blood in the peritoneal cavity on either side.

Internal haemorrhage was thought to be the possible cause for failure of the response for treatment. Laparotomy was done at 5 p.m. under local infiltrative intercostal block regional anaesthesia, 1000 ml of fluid blood was found in the peritoneal cavity and 4-5 big blood clots were removed. Left tube was the seat of an ectopic gestation—tubal abortion.

Left salpingectomy done and right side tubal sterilisation was done. Postoperative period was uneventful.

The false negative report of ultrasound for ectopic made the doctors to think in terms of uterine perforation following evacuation and delayed laparotomy.

Case 2:

Mrs. L.M. aged 30 years was admitted to a private nursing home for pain in abdomen and spotting following 2 M.A.

She had 3 children and underwent sterilisation 3 years back.

On examination patient was pale, pulse 110/mt, Temp. 102°F. Lower abdomen showed slight distension, rigidity present tenderness

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more towards right iliac fossa and lower down. Uterus was of normal size with tenderness in all fornices. In view of temperature, pain and tenderness the possibility of pelvic infection was thought off. In view of amenorrhoea, urine test was done Gravindex showed positive. Since the clinical picture was not clearly correlating with positive gravindex, patient was sent for scanning. The report was in favour of pelvic infection—"Uterus normal size no gestational sac in the uterus, tubes and ovaries not well visualised due to inflammation".

The clinician's opinion possibly correlated with ultrasound. She was put on conservative line of management for pelvic infection—after a negative colpocentesis.

However, the intensity of pain increased, distension increased, colpocentesis was negative but abdominal paracentesis drew free blood. A clinical diagnosis of ectopic pregnancy was made and laparotomy was done. At laparotomy 1 pint of free blood and blood clots were removed Right tube was the site of an ectopic gestation following recanalisation after tubectomy

A false negative ultrasound opinion made the clinician delay the laparotomy for 2 days causing inconvenience to the patient.

IMPENDING POSTERIOR FUNDAL RUPTURE OF UTERUS DUE TO PLACENTA INCRETA

(A Case Report)

By

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Introduction

Impending posterior fundal rupture of uterus by complete placenta increta is an extremely rare condition. A case of an impending posterior fundal rupture of uterus by placenta increta is reported here.

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CASE REPORT

Mrs. J. N., aged 20 years, para 1, Second Gravida was admitted at E.S.I. Hospital Kalyani, West Bengal on July 05, 1987 with a history of eight months amenorrhoea and pain in abdomen for last 10 days prior to admission. She had delivered a stillborn male child 3 years ago.

On Examination

The patient did not appear very pale. Pulse rate was 80/min, volume and tension were good. B.P.—120/80 mm. Hg. P/A the height of fundus was of 34 week size, tender all over the abdomen. No uterine contraction was felt. F.H.R. was 120/minute, Vaginal examination showed a closed cervical os with no effacement and head high up. Provisional diagnosis was premature labour. She was treated by complete bed rest, sedation and Isoxsuprine to prevent premature contraction of uterus. Her Hb% was 60%, P.P. Sugar—90 mg.% and VDRL was negative.

On the night of admission she was unable to sleep because of severe pain in abdomen. On the following morning the patient was examined again and was found to be severely anemic and toxic. She had a pulse rate of 110/min, volume low, B.P. recorded 100/60 mm of Hg. Uterus was of 34 weeks size. There was no uterine tenderness. Vaginal Examination findings were same as before.

Immediate blood transfusion was arranged and other necessary resuscitation measures were adopted. After two units of fresh blood transfusion, Laparotomy was done at 2 p.m. on the second day after admission.

Laparotomy Findings

On opening the abdomen, moderate amount of free blood was seen in the peritoneal cavity. Apparently, uterus was found to be normal and foetus was intact in the uterus. L.U.C.S. was done and a premature female baby weighing 1.5 Kg was delivered. A search was made to find out the source of free blood in the peritoneal cavity. On careful examination, an impending posterior

fundal rupture of uteus as suggested by surface echymosis and slow oozing of blood was seen (Fig. 1). No other pathology was detected apart from this area. Placenta was found to be adhered to that area and no plane of cleavage could be made out (Fig. 2). An attempt was made to remove the placenta without success. Eroded area was also found to be thin.

In the meantime, uterus was found to be very much atonic inspite of conventional measures and syntocinon-drip.

A subtotal hysterectomy was done. Baby died after one hour. Post-operative period was uneventful and the patient was discharged on the tenth day.

MID TRIMESTER RUPTURE UTERUS

By

BISWAJIT GHOSH

Introduction

Rupture uterus is one of the most dangerous complications during labour, very rarely though, during late pregnancy. Here is a rare case report of rupture uterus through fundus during mid trimester (22 weeks).

CASE REPORT

On March 19, 1988, at 10 p.m. Mrs. P. B. 30 yrs. old, 5th Gravida at 22 weeks of pregnancy was admitted as an unbooked case with pain in abdomen and slight vaginal discharge. She had 2 living children born by normal delivery at term. The 3rd and 4th pregnancies ended in abortion at 20 and 22 weeks respectively. Following last abortion, about 1 year back, manual removal of placenta under general anaesthesia had been required in other hospital

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She had average general condition with pulse rate of 92/min, B.P. of 110/80 mm. of Hg. with mild degree of pallor. Heart, lungs were clinically normal. Per abdomen examination revealed 22 weeks size of uterus with mild contraction and tenderness. Foetal parts palpable, and foetal heart sound was audible. Per vaginal examination revealed tubular cervix with closed OS and blood tinged discharge.

She was treated for threatened abortion with absolute bed rest, Inj. antispasmodics, sedative and Isoxsuprine. Routine blood and urine investigations, blood sugar estimation and V.D.R.L. reaction were asked for

She was reviewed next morning (after about 10 hrs.) and found to have slight Temp. (100° F.); tachycardia (140/min.), and 2.0 c.m. dilated OS, with same bloody discharge. She was then thought to be a case of inevitable abortion. Isoxsuprine was omitted, keeping same antispasmodics, sedation and adding antibiotic. Hb% was 7.5 Gm.%, other investigations being normal.

Next day early morning again she started complaining of pain in abdomen with increased discomfort. On examination, pallor was found to be slightly increased with persisting tachycardia and same 100 °F. temp. Fundal height increased to 26 weeks size, with tense and distended abdomen. Foetal parts could not be palpated any more and no foetal heart sound was audible. Per vaginal examination recorded same findings as before. There was no feature of shock.

X-Ray of abdomen showed a high up position of foetus of 22-24 weeks size with no soft tissue shadow surrounding.

Immediate laparatomy was done making arrangements for 2 units of blood transfusion. On opening the abdomen, the foetes enmasse with the placenta and cord within the intact sac was found floating in the peritoneal cavity It was also delivered intact by careful manoeuver to avoid liquor contamination. Blood clots and blood mopped out and the uterus was found to be of the size of about 14-16 weeks having a fundal rupture with irregular margins extending from one cornu to the other. Hysterectomy was performed. Post operative period was totally uneventful and the patient recovered quickly and was discharged from hospital on the 9th post-operative day.

Acknowledgement

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See Figs. on Art Paper II

TUBERCULAR HEPATIC GRANULOMA—UNUSUAL CAUSE OF PUERPERIAL PYREXIA

(A Case Report)

By

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SUMMARY

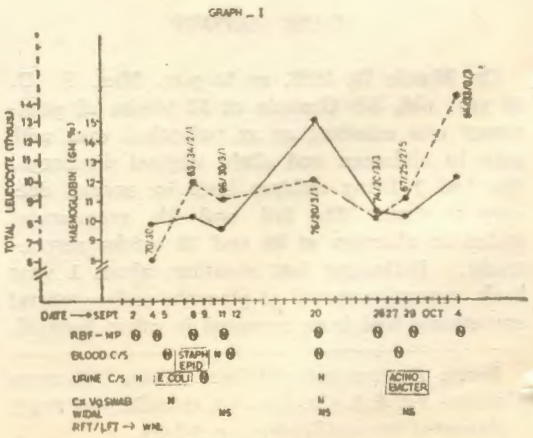
An interesting case of prolonged puerperal pyrexia following caesarean section thoroughly investigated, ultimately found to have hepatic granuloma (Tubercular) is being reported.

CASE REPORT

Mrs. N.R. 25 years second gravida was admitted in labour ward of Postgraduate Institute of Medical Education and Research, Chandigarh, on 30-8-86 at 33 weeks gestation with premature rupture of membranes for 12 hours. She had her first baby delivered by LSCS 2 years back, female child alive and well. On abdominal palpattion height of uterus was corresponding to period of gestation, lie of the fetus was oblique with head lying in RIF, FHS 144/mt. regular. She was getting mild uterine contractions. Vaginal findings were cervix 25% effaced, one finger loose, frank leakage++. Ampicillin 500 mg. 6 hourly was given. Emergency LSCS was done. Live male baby weighing 1.8 kg. was delivered in good condition. Immediate post-operative period was uneventful. From the third day of puerperium she started having high grade fever, spikes touching 40.5° to 41°C not associated with chills and rigors, no foul smelling discharge per vaginum. Fever continued for 50 days. Throughout this period the only symptoms she had were dysuria for 4 to 5 days from 5th post-operative day, loose motions for 4 to 5 days from 30th post-operative day and anorexia throughout. On examination the only positive finding was palpable liver 5 to 6 cm BCM non-tender and smooth spleen was not palpable. Uterus was well involuted and non-tender. Repeated pelvic examinations did not reveal any mass in fornices or any bogginess in pouch of Douglas.

The patient was thoroughly investigated as shown in Graph I. The only positive culture was one of the urine samples sent on 5th post-operative day which was treated with suitable antibiotic. The patient received a number of antibiotics and anti-malarias as shown in Graph II. A number of special investigations were also done including IVP, Chest screening, ultrasonogram, echocardiogram, Sigmoidoscopy, culdocentesis and liver scan. Ultimately liver biopsy was done on 8-10-86 which was reported as Tubercular Granulomatous He patitis. Patient was started on anti-tubercular therapy (Rifampicin, INH, Ethambutol and Pyridoxin), to which she responded.

GRAPH - I



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