Secondary Abdominal Pregnancy Following Rupture of Rudimentary Horn.

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Secondary Abdominal Pregnancy, a rare entity, with its variegated clinical features almost always follows early rupture or abortion of a tubal pregnancy into the peritoneal cavity. Here we report a case of pregnancy in rudimentary horn, which ruptured giving rise to Secondary Abdominal pregnancy.

Mrs. P.H., 21 years, Primigravida, married for one year; LMP – 21-5-2000 was admitted in the Female Medical Ward of Calcutta National Medical College on 18.9.2000 with acute abdominal pain and vomiting. The patient also gives history of being admitted in a Nursing Home with the same complaints on 17.8.2000. The patient was treated there with IV fluids, antibiotics and she received two units of B+ve blood. Pregcolor was positive on 24.8.2000 and the patient was discharged with antenatal advice.

The patient was treated in Female Medical Ward with IV fluids and antispasmodics and the patient improved with conservative treatment. Three days later she started having slight vaginal bleeding for which she was referred to the Gynaecology Department. On examination, pallor ++, pulse 98/min, BP-110/70, P/A-mild suprapubic tenderness, a suprapubic lump of 16 weeks size was felt.

P/S-cervix soft, slight brownish discharge present. P/V – uterus 16 weeks size. A provisional diagnosis of Missed Abortion was made and the patient was transferred to Gynaecology Department.

Investigations –
Hb-8.5 gm%, TC-9800/cmm, N-68, L-24, M-6, E-2. Blood group B+ve, VDRL-negative, PPBS-112mg%.

USG-Uterus bulky, with empty cavity. A sac of about 15cm diameter with a foetus of 15 weeks 5 days present without any cardiac pulsation. The placenta seemed to be located near the fundal region of the uterus. A provisional diagnosis of Secondary Abdominal Pregnancy was made.

Laparotomy was undertaken on 28.9.2000. Abdomen was opened by midline vertical incision. The parietal peritoneum was adherent to the underlying omentum and gut. Adhesions were cautiously broken and peritoneal cavity was entered. A tough sac with adherent gut and omentum was carefully dissected and the cavity opened. A foetus of about 16 weeks was inside which was removed. The margins of the sac were excised. The cord was followed to placental insertion at the fundus and the posterior aspect of uterus. The placenta was removed without much difficulty. On further exploration it was found that the right lateral side of the uterus was adherent to a solid mass of about 7 cm by 5 cm in diameter and greater omentum was densely adherent to the mass. The mass on careful examination was found to be a rudimentary right horn with round ligament and adnexae well defined. Omental adhesions with the rudimentary horn (the presumed site of rupture) were separated and excision of the rudimentary horn was done. Abdomen was closed in layers after ensuring satisfactory haemostasis. The patient was transfused four bottles of B+ve blood. Her postoperative period was uneventful and the patient was discharged on 11.10.2000.