COMBINED INTRAUTERINE AND ABDOMINAL PREGNANCY WNFHU%1LI) BY LAPAROTOMY

Pages with reference to book, From 61 To 62

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INTRODUCTION

Two unusual cases of advanced twin pregnancy are described in both cases one foetus was in the uterus and other in the abdominal cavity. Combined intrauterine and extrauterine pregnancy was first reported in 1708 AD. It has been mentioned in recent literature that an intra-uterine pregnancy rules out an ectopic pregnancy, but this is no longer considered true. Because heterotopic pregnancy now a days is not thought to be a medical curiosity, it should always be considered in differential diagnosis of abdominal pain pregnancy[1]. The incidence of heterotopic pregnancy is higher in certain high risk groups. However no risk factor was identified in both the cases mentioned here.

CASE 1

A 35 year old woman para6was admitted in Liaquat Medical College Flospital, Jamshoro on November 20, 1982 with history of home delivery 8 days back and severe abdominal pain, persistent vomiting and fever for the last 7 days. She was para 4; all normal vaginal deliveries conducted by TBA (traditional birth attendant) at home. General physical examination revealed an anxious pale lady obviously distressed by pain. Her pulse rate was 110 perminuteand blood pressure of 110/7OmmHg. Shewas pyrexial with a temperature of 39°C. She was moderately anaemic and dehydrated. On abdominal examination there was a tense, tender, ill defined mass corresponding to 24 weeks of gestation palpable in right iliac fossa and right lumber region. Pelvic examination revealed a tender mass of variable consistency in right lateral and posterior fornices. Laboratory investigations showed Hb 8 gms/dl, ESR 94 mm 1st hour reading, TLC $14x10^9$/L with neutrophilia. Fligh vaginal swab revealed growth of E. coli sensitive to ampicillin. Ultrasound facility was not available at that time in Liaquat Medièal College Hospital. Provisional diagnosis of tubo-ovarian mass or ovarian tumour developing secondary infection was made.

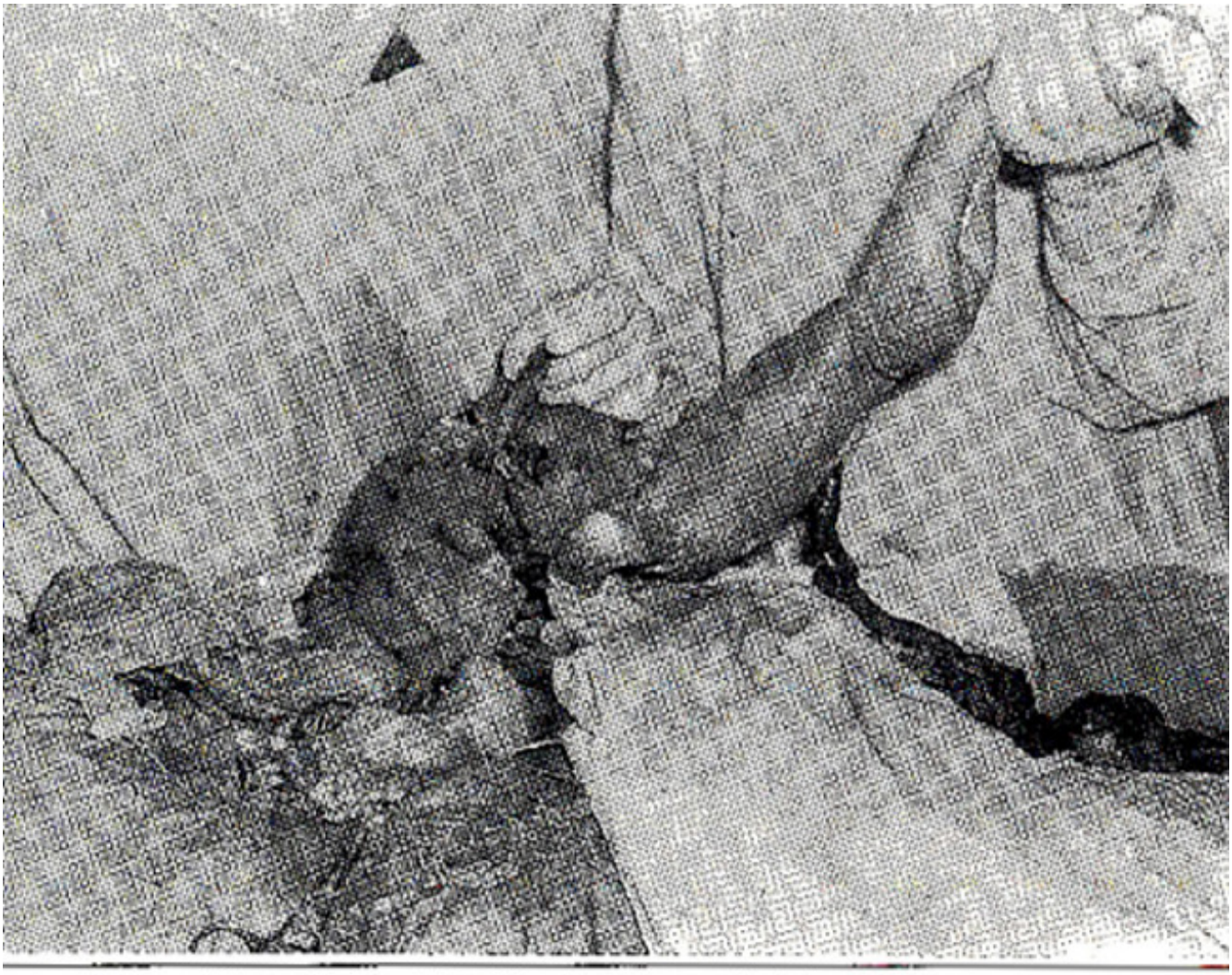

Figure 1. Combined intrauterine and abdominal pregnancy.

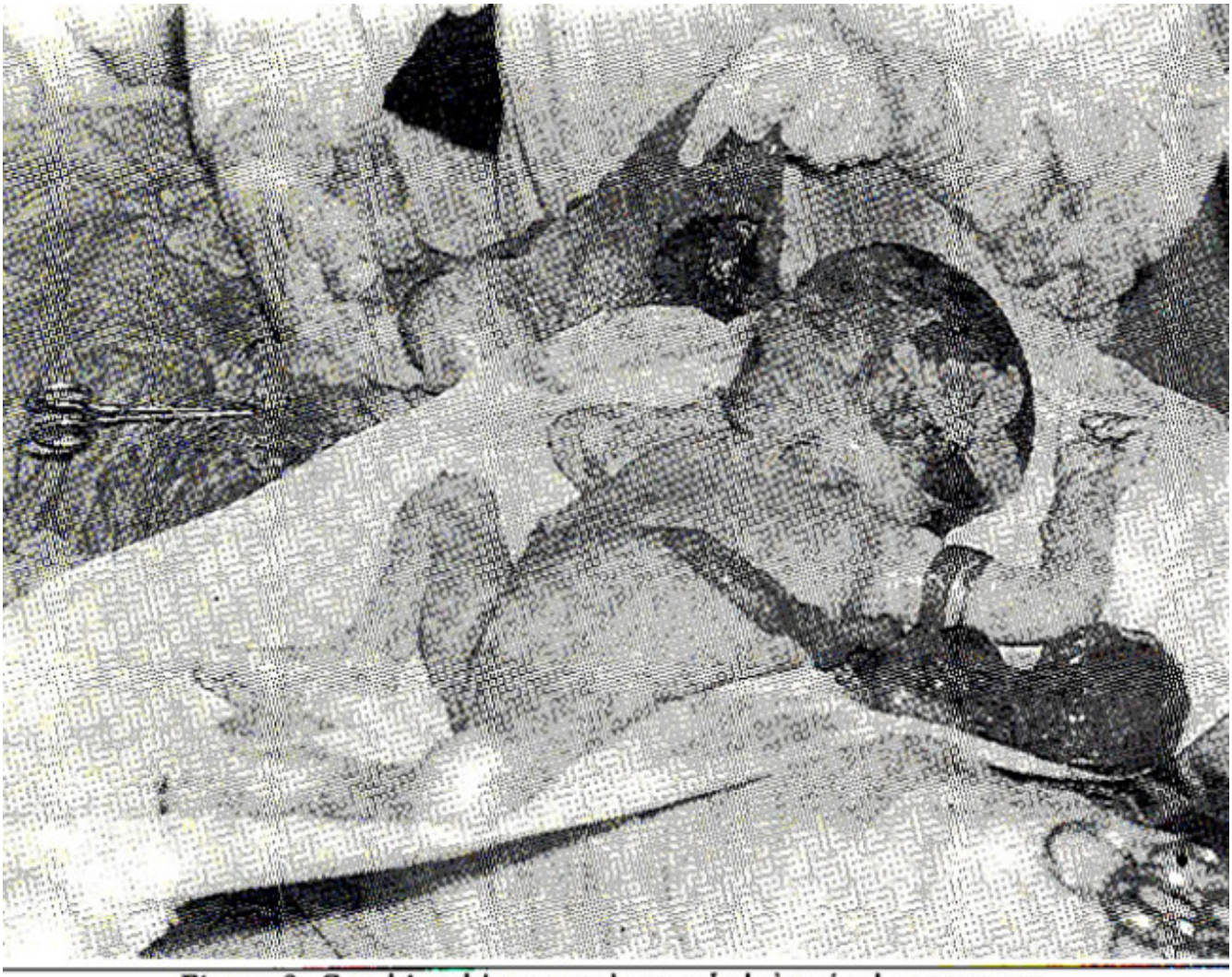

Figure 2. Combined intrauterine and abdominal pregnancy.

Parenteral antibiotics were commenced to combat infection and intravenous fluids administered to correct dehydration. Laparotomy was performed on November 22, 1982. A small amount of foul smelling dirty coloured fluid was found filling the peritoneal cavity. A thick walled sac was attached to the right side of uterus and right ovary and fallopian tube. The sac was incised and a malformed maccrated foetus of about 24 weeks gestation was delivered. The placenta was firmly adherent to the ovary and tube and hence its removal necessitated right salpingo-oophorectomy. Total amount of blood loss during operation was about 300 ml. Patient remained pyrexial during postoperative period but subsequently settled on broad spectrum antibiotics.

CASE 2

A 30 year old woman para 5+2 presented to the department of obstetrics and gynaecology, People's Medical College Hospital, Nawabshah on March 15, 1990 complaining of abdominal pain and distension following home delivery 10 days ago. At the time of admission, on physical examination, she appeared to be in pain, was mildly anaemic and dehydrated having temperature of 38°C. A poorly defined tender abdominal mass corresponding to 34 weeks of gestation was palpable. Pelvic examination demonstrated subinvoluted uterus with cervix displaced anteriorly. A cystic tender mass was felt in the posterior and left vaginal fornices in continuity with abdominal swelling. Laboratory data showed Hb 9 gms/dl, ESR 50 mm 1st hour reading, TLC 12. $5x10^9$ and normal renal andliver function tests. High vaginal swab and mid-stream urine did not reveal any growth. Routine ultrasound examination could not be carried out in this case due to some technical fault in the machine. Based on

the clinical presentation and laboratory data a provisional diagnosis of ovarian tumour with complications was made. Exploratory laparotomy was performed 6 hours later. On opening the abdomen there was no blood or free fluid in the peritoneal cavity. A thick walled cystic mass was found adherent to the posterolateral aspect of uterus, the left broad ligament and rectovaginal pouch. During dissection the sac ruptured and a full term macerated female foetus weighing 2.0 kg was delivered. The placenta was attached to the posterior aspect of the uterus. Fortunately there was no difficulty in separation and removal of placenta. Patient had an uneventful postoperative recovery.

DISCUSSION

Ultrasonography would have been useful in diagnosing both cases but unfortunately could not be carried out which limited our preoperative diagnosis. In case 2, abdominal foetus was fully developed with no congenital anomaly and would' have 'been saved if condition was diagnosed earlier when the foetus was still alive. In case 2 maternal morbidity would have been reduced by early surgical intervention. Abdominal pregnancy is a rare form of pregnancy; incidence varies from 1:6,000 to 1:10,000 term births2. Pregnancies occurring simultaneously in different body sites (heterotopic pregnancies) is still a rarer event occurring in 1:30,000 term births[3]. The current epidemic of PID (pelvic inflammatory disease) and recent advances in gynaecological techniques of assisted reproduction such as in vitro fertilization and wider use of ovulatory induction drugs have increased the incidence of combined intra and extra uterine pregnancies[4,6]. The abdominal pregnancy produces considerable morbidity and mortality both for foetus as well as mother, the maternal mortality rate may reach up to 18%. The major causes of maternal death are sepsis, haemorrhage, bowel complications and difficulty in separation of placenta. The factors which decrease maternal mortality may depend upon either earlier diagnosis[7-9] or prompt surgical intervention[10,11]. Early diagnosis depends on high index of suspicion of heterotopic pregnancy[7] and utilization of technical aids such as transvaginal ultrasonography which is the most sensitive index in the diagnosis of early ectopic pregnancy[8,9].

ACKNOWLEDGEMENT

I would like to express thanks to Professor Aftab Munir for the excellent guidance and assistance. Grateful acknowledgement is also made to Dr. S.H. Piriyani for helping in the preparation of this manuscript.

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