

Abdominal Pregnancy With Difficult Diagnosis

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Kanta, a 25-year old woman was admitted to the labour room on June 16 with the history of abdominal pain at about 35 weeks of pregnancy.

Ante-natal history: Primigravida

Last menstrual period: October 16 (preceding year)

Expected date of delivery: July 23.

She attended ante-natal clinic only once at 34 weeks of pregnancy. The presentation could not be made out. The blood pressure was 130/90 and there was a little swelling of the feet. She was advised admission but she declined. Therefore, she was advised to take more rest at home. Esidrex 25 mgs. O.D. and phenobarbitone 30 mgs. T.D.S. was ordered.

Examination on Admission

She looked healthy. According to her dates the period of pregnancy was 35 weeks, however the fundal height was equivalent to term. The presenting part was not well defined as the whole of the abdomen was quite tense. It was a longitudinal lie and thought to be a breech. The foetal heart-sounds were regular, 130 per minute; and were heard in the right hypochondrium. The blood pressure was 130/90, pulse 90 per minute, temperature 98 °F.

There was no history of bleeding or pain in the early months of pregnancy and no vaginal discharge. She experienced nausea throughout pregnancy. She complained of pain in the abdomen for one week which seemed to be associated with the foetal movements. The more the baby moved the more pain she had.

Management

On admission the patient was prepared for labour. An injection

of morphia 10 mgs. and phenergan 50 mgs. was given for pain which was thought to be caused by labour. A toxæmia chart was ordered. There was no albumen or acetone in the urine. An intake and output chart was kept. A half-hourly record of foetal heart, pulse and contractions was ordered, but she seemed to have no contractions of the uterus. No cause for pain was found. The pain ceased the next day. The blood pressure was 120/80 and foetal heart 140 per minute. There was no albumen nor acetone in the urine. She had 100 °F temperature with no obvious cause.

June 18. The patient had no complaints. She was transferred to the ante-natal ward and the toxæmia chart was continued. The blood pressure was 130/90 and foetal heart 140 per minute. The same sedation was ordered.

June 19. On account of difficulty in palpation of the foetus the patient was sent for X-ray of the abdomen. The X-ray report said: "There was a single pregnancy breech presenting. The sacrum is pointing to the right. The head is in the right upper quadrant and the size of the foetus is normal, but there is marked lateral flexion at the neck of the foetus. Because of the foetal movements the further details could not be seen."

June 20. The tablets of phenergan were stopped and phenobarbitone 100 mgs was started 6-hourly. A vaginal examination was done. The cervix was one inch long and the cervical os was closed. An abdominal examination was done. The bundus could not be made out clearly as the upper abdomen was distended.

June 21. The blood pressure was 140/90. Serpasil 0.25 mgs. O.D. was ordered and sedation and general treatment was given as before. The diagnosis was mild "preeclamptic toxæmia" and breech presentation.

July 6. At 38 weeks of pregnancy a vaginal examination was done. The cervical os admitted one finger tip. She was advised induction of labour to deliver the child at about 39 weeks of pregnancy.

July 10. Oxytocin (syntocinon) drip was started with 2.5 units in 500 mls of 5% dextrose. The initial rate was 10 drops per minute (3 milli units per minute). The rate increased by 10 drops every 20-30 minutes up to 40 drops per minute. (12 milli units per minute) as contractions were very infrequent. Foetal heart sounds, pulse and blood pressure were recorded half hourly. There were no uterine contractions felt by the patient but it was thought that Braxton-Hicks contractions were present about every 5-10 minutes.

July 11. The same drip was given but again no labour contractions were felt by the patient. Treatment and drugs were given as before.

July 12-13. An oxytocin (syntocinon) drip was started, with 10 units in 500 ccs of dextrose 5% at the rate of ten drops per minute (12 milli units per minute). The same drip was given the next day up to 40 drops per minute (50 milli units per minute). There were no uterine contractions. Vaginal examination was done. The cervix was very posterior in the pelvis. One inch long, admitted one finger tip.

Complete absence of uterine contractions enabled the diagnosis abdominal pregnancy, but the uterus could not be felt separate from the pregnancy. It was decided to perform Caesarean section on her on July 15.

July 14. The consent for operation was taken from her husband. The abdominal and perineal preparation was done. Blood was sent for grouping and cross matching and two bottles of blood were

arranged. Sodium amytal 3 grs and phenergan 50 mgs were given at 11 p.m. She slept well during the night.

July 15. The preparation for operation was completed. Pre-medication, an injection of phenergan 50 mgs. intramuscularly was given at 7 a.m. The patient was taken to theatre at 8 a.m. Epidural anaesthesia was given at 8.10 a.m. using 25 mls of 1.3% lignocaine and 0.25% amethocaine with 0.25 mg. of adrenaline. The patient seemed to be nervous and upset. Injection pethidine 50 mgs. was given. Thiopentone 150 mgs. was given later with minimal administration of Ether and Nitrous Oxide.

The operation started at 8.25 a.m. A midline subumbilical incision was made over the abdominal wall and the peritoneal cavity was opened. The first thing seen was unusual. The placenta was lying under the abdominal wall but was not attached to it. As the placenta was anterior, a hand was introduced further into the abdomen and it was found that the foetus was contained in an amniotic sac lying behind the placenta. There were a few small adhesions to the omentum. The entire mass was arising from the right adnexal region. The uterus was palpated behind the mass. Large blood vessels were seen arising from the right broad ligament area spreading out over the "maternal" surface of the placenta. The amniotic sac was broken into and the foetus extracted by the breech. A little liquor was present. As there was no bleeding no attempt was made to dislodge the placenta from its attachment to the right broad ligament. The placental blood was allowed to escape and the cord was cut and ligatured close to the placenta. The uterus was displaced towards the left side. It was soft, very bulky and the size of about an 8-week pregnancy. The left tube and ovary were normal but those on the right side could not be seen.

Diagnosis : Abdominal pregnancy probably resulting from a tubal ectopic pregnancy invading the broad ligaments.

The abdomen : The placenta

was left inside. There was no bleeding from anywhere. The abdomen was closed in layers. Tension sutures and Michel clips were inserted and the patient was transferred to the ward in a satisfactory condition at 9.30 a.m.

Puerperium : Intravenous fluids, dextrose 5 per cent 3,000 ccs. were ordered for 24 hours. An injection of Vitamin B complex 2 ccs and an injection of Vitamin C 500 mgs were given in the drip. An injection of morphia 10 mg. and an injection of phenergan 50 mgs. intramuscularly were given 4 hourly for 24 hours. An intake and output chart was kept. Blood pressure and pulse were recorded $\frac{1}{2}$ hourly for two hours and then hourly. The blood pressure was 110/70, pulse 96 per minute and they remained steady.

Next day, she was started on oral fluids 2 ounces 1-2 hourly as boiled water and tea. Intravenous fluids dextrose 5 per cent 1,500 mls were given. An injection of morphia 10 mgm was given 4-6 hourly P.R.N. The blood pressure, pulse and temperature recorded 4 hourly and were normal. The bowel sounds were present, the abdomen was soft and the chest was normal. There was no pyrexia and therefore no antibiotics were given.

Total intake 3,180 mls. Total output 150 mls. and this was insufficient for the 24 hours of the first day.

Light diet was started and the urinary output was good. A soap and water enema was given on the third day with a good result. The sedation was stopped. It was expected that there would be no lactation but she had engorged breasts. An injection of stilboestrol 15 mgms was given intramuscularly stat and oral tablets were ordered 5 mgs T.D.S. for 3 days. 5 mgs. B.D. for 2 days and 5 mgs. O.D. for one day. The clips were removed on the 6th day and union was good, and the stitches were removed two days later. The patient was discharged in a satisfactory condition on the 11th day. She was advised to come for post-natal check up after 6 weeks.

Baby : It was a female infant severely asphyxiated. Active resuscitation was immediately started by the staff nurse and assisted by another senior doctor. Respirations were never established. The apgar score after one minute was one. The only sign of life was a slow heart beat. The baby expired after half an hour. She had talipes equinovarus of both feet. Post-mortem examination was refused so it was not known if there were internal congenital abnormalities. The birth weight was 6 pounds and 2 ounces. Cause of death was certified as anoxia.

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(Obstetrics—Contd. from p. 42)

freedom from puerperal infection are concerned, we say to you—"proceed quietly and humbly and be grateful for small mercies". Think about these conditions associated with what we have described as the pursuit of affluence and happiness. Expect new diseases from new drugs. Encourage the study of prematurity, dysmaturity, and mental retardation. Improve our methods of analgesia in obstetrics because they have lagged behind. Do not forget the mother between her pregnancies. If you are just an ordinary person, as most of us are, you can still give great service to your profession by being faithful in little things, by being exact in case recording by announcing your ideas and experiences, and by bestowing a fair deal upon all with whom you come in contact.

(The above is summary of lecture given by Professor J.K. Feeney at the 1969 Refresher Course for Midwives as appeared in the Irish Nurses' Journal, September 69).

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