

ABDOMINAL PREGNANCY IN A PATIENT WITH TUBAL LIGATION

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Abstract

The patient in this case report presented with lower abdominal pain, intraperitoneal bleeding and shock. She gave history of amenorrhoea for two months and had tubal ligation done ten years back.

After adequate resuscitation laparotomy was done which revealed an abdominal pregnancy. The placenta was found to be attached to the pelvic peritoneum adjacent to a ruptured right fallopian tube. Both the tubes showed evidence of previous tubal ligation. Partial salpingectomy of the right side and religation of the left tube was done. Histopathological examination revealed evidence of recanalization of the right tubal scar.

Keywords : Ectopic pregnancy, abdominal pregnancy and acute abdomen.

Introduction

An ectopic pregnancy is one in which implantation occurs in a site other than the normal uterine cavity¹. Its frequency varies from 0.1% to 3.6% depending on geographic location and race². Ninety five percent of all the cases affect the fallopian tubes. Abdominal pregnancy accounts for only 1% of all ectopic pregnancies³. The incidence of abdominal pregnancy is 1 in 7269⁴. Curiously the patient in this study had tubal ligation done ten years back. It is for this reason that the case is being reported.

Case Report

The patient aged 38 years, was admitted to a local hospital on 27th february 1994 with history of lower abdominal pain for seven days. She was provisionally diagnosed by the referring doctor as a case of acute abdomen. Detailed history revealed amenorrhoea for two months. She was severely anemic and abdominal examination revealed a scar of previous tubectomy done ten years back. On palpation there was a tender lump in the right iliac fossa. The patient was in shock on admission,

and resuscitation by fluid and blood was done.

A routine blood and urine examination along with a KUB X-ray was done. A pregnancy test was carried out but it came out negative. Ultrasonogram of the abdomen could not be done because of nonavailability of the facility in the hospital and the precarious condition of the patient. An emergency laparotomy was done as there was evidence of intraabdominal bleeding. The peritoneal cavity was found filled with blood. After clearing it up by suction and mop an aborted abdominal pregnancy was found. The product of conception was not identifiable but the placental attachment was revealed at the pelvic parietal peritoneum on the right side adjacent to the right fallopian tube. It was left undisturbed because of the fear of uncontrollable hemorrhage which can ensue if removal is attempted. Both the tubes showed evidence of previous ligation at the region of the isthmus. The right tube was found perforated in the ampulla at its antimesenteric border. The uterus was slightly bulky and both ovaries were normal. Partial salpingectomy was done on the right side. The site of previous ligation was included in the excision to allow histopathological examination for evidence of any recanalization of the fallopian tube. The opposite tube was religated and after proper peritoneal toileting abdomen was closed in the usual manner with a drain in the right iliac fossa. The patient recovered uneventfully and stitches were removed on seventh postoperative day.

Discussion

There has been a few reports of abdominal pregnancy in Bangladesh^{5,6,7}, some of which went to term. Only one patient delivered successfully (by laparotomy) a living child⁶. The patient in this case report had an abdominal pregnancy which ended unsuccessfully at two months. It is an example of secondary abdominal pregnancy as there was evidence of right sided tubal rupture.

Production of chorionic gonadotrophin in ectopic pregnancy is often inadequate and thus standard pregnancy test may be negative in upto 50% of cases². The operation for abdominal pregnancy is dangerous and great skill and gentleness are necessary if serious hemorrhage is to be avoided¹.

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Removal or trimming of the placenta has been advocated by Macdonald². But the traditional teaching is to leave the placenta undisturbed⁸. Leaving the placenta behind usually poses no problem since it is absorbed in time. Only rarely it may give rise to intra-abdominal infections.

The interesting point in this case report is that the patient had a proper tubal ligation done ten years back. In spite of this fact the patient conceived which ultimately ended up in an abdominal pregnancy. A Begum⁹ reported a case of ovarian pregnancy in which the patient had a ligation operation done previously. She did mention the presence of tubectomy scars on both the tubes, but there was no mention of histopathological evidence of tubal recanalization.

In the present case, proper histopathological examination was done with serial sections including a longitudinal section, which revealed mucosal continuity through the scar of previous ligation. It is well known that the fallopian tubes have a natural tendency to recanalize¹⁰. It is also true in case of vas deferens¹¹, where extensive study has been done to find out the pathogenesis of recanalization.

In view of the potential of the tubes for spontaneous recanalization it is important to pay due consideration to two things in clinical practice. One is the surgical technique of tubectomy (failure rates vary from one technique to the other). The other is the readiness of the clinician to entertain a diagnosis of ectopic pregnancy when a patient comes with acute abdomen and severe anaemia even if there is history of previous tubal ligation.

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