

exclude uterine pregnancy. However, it is felt that the chief reason for missing the diagnosis was failure to keep its possibility in mind in a woman with unusual clinical features of pregnancy.

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2. Cross, J.B. Lester, W.M., and McCain, J.R. (1951). The Diagnosis and Management of Abdominal Pregnancy with a Review of 19 cases. *Am. J. Obst. & Gynec.*, 62: 303.
3. Dixon, H. G. and Stewart, D.B. (1960) Advanced Extrauterine Pregnancy. *British Medical Journal.*, 2: 1103, 1960.



tube, and was mobilised with great difficulty.

The hypertrophied and thickened right Fallopian tube had to be removed with the sac. The macerated foetus weighed 980g and the placenta weight 200g (Fig.1.) Post-operative recovery was uneventful, apart from pyrexia which settled with antibiotics.

#### COMMENT.

Abdominal pregnancy is a rare condition and the diagnosis is often missed unless it is kept in mind. The diagnostic features, described by Eastman and Hellman in William's textbook of obstetrics, are as follows:

- a) A history of irregular bleeding and pain in early weeks.
- b) Course of gestation is prone to be uncomfortable as a result of peritoneal irritation with nausea, vomiting, flatulence, constipation, and diarrhoea.
- c) Late in pregnancy, foetal movements may be very painful.
- d) Examination late in pregnancy often reveals a foetus high in the abdomen, which is frequently in shoulder presentation.
- e) Abdominal tenderness, which makes palpation of foetal parts difficult.
- f) Braxton Hicks contractions are absent and round ligaments are not palpable.
- g) The cervix is usually displaced and may undergo

dilatation upto 2 cm in spurious labour, but effacement does not occur.

Corss and his collaborators<sup>2</sup> have emphasised the oxytocin test as being the most valuable single aid in early diagnosis of abdominal pregnancy. If an intrauterine pregnancy is present, the uterine wall surrounding the foetus goes into a state of contraction following  $\frac{1}{2}$  to 1.5 units of oxytocin given subcutaneously.

In their extensive paper on advanced extrauterine pregnancy,<sup>3</sup> Dixon and Stewart have stressed the diagnostic value of a maternal vascular soufflé, louder than a normal uterine soufflé, which is heard over a small area of the abdomen just medial to the iliac spine on the side on which the placenta is located. Although not present if the foetus is dead, this is said to be a fairly constant sign of abdominal pregnancy with a living foetus.

Radiological examination is said to be particularly helpful, for it not only reveals an unusual foetal attitude and position but gas shadows of coils of intestine superimposed on the foetal skeleton. Hystero-graphy confirms the diagnosis, but cannot be employed so long as there is any chance of the pregnancy being within the uterus.

The diagnostic clinical features in the reported case were:

- a) History of bleeding and acute abdominal pain in the early months of pregnancy.
- b) Tense uterus with difficulty in feeling foetal parts.
- c) No uterine contractions in spite of repeated Syntocinon infusions.

The ultrasound report was misleading, as it did not

## A Misdiagnosed Case of Abdominal Pregnancy

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A case of abdominal pregnancy is reported, in which the diagnosis was missed and repeated attempts were made to induce labour with Syntocinon infusions before it was decided to terminate pregnancy by "Caesarean Section".

### INTRODUCTION

Abdominal pregnancy is a relatively rare condition the incidence ranging from 1 in 2,081 to 1 in 50,820 deliveries. The diagnosis of a case can be surprisingly difficult and many are missed until late in pregnancy when, for some reasons such as an attempt to induce labour, the attendant fails to find membranes to rupture and discovers the uterine cavity to be small and empty.

### Case Report:

Mrs. R., aged 25 years, was admitted to the Gynaecology Department of Civil Hospital in May 1983, complaining of amenorrhoea of 10 months duration with loss of foetal movements for three months. She was married for six years and had undergone dilatation and curettage twice, before conception occurred ten months prior to admission.

She had the usual symptoms of nausea and vomiting, when pregnancy was confirmed by her doctor in the tenth week. Two weeks later, she developed severe abdominal pain and vaginal bleeding following coitus. These symptoms settled spontaneously after a few hours. There was no further problem and pregnancy advanced uneventfully into the eighth month, when foetal movements became sluggish and then ceased completely. Foetal death was confirmed by ultrasound and induction of labour with Syntocinon infusion was attempted by her doctor. As it failed, the patient was discharged and then readmitted twice at monthly intervals for repeat infusions. Finally, she was referred to Civil Hospital for termination of pregnancy by "Caesarean Section".

On admission, her general condition was satisfactory. The blood pressure was 110/75 mm Hg and the puls was good in volume. The abdomen was soft and non-tender. The "uterine" size appeared to be consistent with 28 to 30 weeks' pregnancy. The "uterus" felt tense and foetal parts could be palpated with difficulty. The presenting part was not made out and foetal heart sounds could not be heard. There was no tenderness during abdominal palpation and the "uterus" was symmetrical in shape. On vaginal examination, the cervix was found to be long and the os was tightly closed.

As medical induction had failed on three occasions and the patient was anxious to have her pregnancy terminated, it was decided to perform "Caesarean Section".

On opening the abdomen, it was noticed that the "uterine" walls were thin and avascular. An incision was made in the "lower segment" and a macerated baby with placenta was extracted from a cavity full of pus. When an attempt was made to massage the sac to make it contact, the uterus slightly enlarged was discovered lying in the pouch of Douglas. It was then realised that we were dealing with an abdominal pregnancy. The sac was adherent to omentum, intestine, and right Fallopian

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