TWIN PREGNANCY WITH AN INTRA ABDOMINAL FOETUS OF 28 WEEKS GESTATION

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INTRODUCTION

A heterotypic pregnancy is defined as a multiple gestation with implantation at different sites.[1] It is thought to arise from fertilization of double ova by superfecundation or superfetation, in which another ovulatory event results in an intrauterine pregnancy, in the presence of ectopic pregnancy.[2]

Primary abdominal pregnancy, with the first and only nidation onto a peritoneal surface is rarely reported, and three criteria for its diagnosis had been reported.[1] The tubes appear normal with no evidence of previous nidation[2] there is no utero placental fistula or evidence of uterine rupture.[3] the conceptus is exclusively attached to peritoneal surfaces.[3] Secondary abdominal pregnancy is the most common and may result from tubal abortion, or rupture of a previous uterine incision. The pregnancy may result in a viable infant as a result of secondary vascularization from peritoneum.[4] The case discussed did not fit into any of the above mentioned categories.

CASE REPORT

This 35 years old lady, presented to a private clinic with amenorrhoea of 5 months duration, pain hypogastrium, and mass abdomen. She was admitted to Lady Reading Hospital after an abdominal and pelvic ultrasound. She had been married for 16 years. Her first pregnancy ended in an emergency Caesarean Section for transverse lie and delivered an alive male baby. Post operative period was uneventful. Her second pregnancy ended up in delivery of a still born female, a breech delivery at home. Third time she delivered an alive male baby at home. Fourth pregnancy ended up with a birth of dead female foetus at 28 weeks in a hospital.

Her fifth pregnancy was a stormy one. Ultrasound on 30.04.97 reported, a single intrauterine dead foetus, with cephalic presentation. Femur length corresponded to gestational age of 30.6 weeks with placenta anterior, marginal previa and adequate amniotic fluid. She was admitted to Lady Reading Hospital on 03.05.97 for labour induction because of intra uterine death. Prostin E–2 vaginal pessaries were inserted twice at six hourly interval, but the patient left the hospital and got admitted in another local hospital on 05.05.98. She was given intravenous antibiotics for three days Labour was induced again with vaginal Prostaglandinpessaries, inserted on 05.05.97 and repeated on 15.05.97 and intravenous infusion of oxytocin starting with 2.5 I.U and gradually increasing to 5 I.U. She had following investigations for Bad Obstetrical history, Blood group B Positive, Hb 10.79 gm%, Bleeding Time 2.15 min, Clotting

Time 3.4 min, Blood Urea 23 mg%, Blood Sugar 85 mg%, TORCH Screening was negative.

As the induction of labour failed, she was sent home for ten days on oral antibiotics and iron. At home she bled profusely, passing big clots. She did not recall passing placenta or foetus and never consulted a doctor until her recent admission. She had resumed normal menstruation for 8 months prior to admission.

The Ultrasound report on 05.02.98 revealed Twin intra uterine gestation with foetal heart activity. Gestation age 14+5 weeks. Placenta anterior and posterior. Right side of abdomen having a cystic mass containing macerated foetus, long bones and spine identified. Longest bone measuring 5.2 cm corresponding to gestational age of 28 weeks. She was admitted to Gynae unit in Lady Reading Hospital on 07.02.98.

She was tall 5 feet 5", weighing 95 kg. Temperature was 98 F, pulse 80/min and regular, and blood pressure was 130/80 Hg. She was neither in pain or in distress. No other abnormality was detected. Abdominal examination revealed old pfannensteil scar, uterus size corresponding to 18 weeks gestation. A 11x11 cm globular, mobile mass was felt separate from the uterus on its right side. It was smooth and non tender. No other viscera or mass was palpable. Pelvic examination showed uterus of 18 weeks gestation, Fornices were clear, the mass felt abdominally being high. Investigations showed Hb 12.2 gm%, Blood sugar was 118 mg%, and Coagulation profile including plated count was normal. X–ray chest was unremarkable.

Laparotomy was planned to deliver the dead foetus from abdomen. A longitudinal incision was preferred, rather than going through the old scar. There was no free fluid or adhesions in the peritoneal cavity. Uterus was of 18 weeks gestation. There was 11x11 cm well encapsulated mass, wrapped in omentum and loosely attached to the right end of the previous Caesarean section scar. Tubes, ovaries and the rest of the uterus were normal.

The mass was separated from omentum, colon, and the uterus. It was sealing a 2 cm rent in the uterine scar, and a part of placenta and shining foetal sac were peeping through this rent. In order to preserve the current pregnancy, it was decided to replace the amniotic sac and repair the rent, but the rent got bigger with the foetal movement and the first twin with intact sac was expelled through the scar, followed by the second twin and its detached placenta. This was followed by placenta of first twin. The uterus was closed in two layers as the patient had not completed her family. The post operative period was uneventful and she was discharged after 8 days.

DISCUSSION

We have not come across such a case in the literature and believe this is a unique case. Our theory is that in her previous pregnancy, because of oxytocic drugs used for induction of labour, the uterine scar ruptured silently, extruding the foetus along with its sac in the peritoneum. The placenta, as it was praevia, might have been passed vaginally, unnoticed along with huge clots. It could not have been a secondary abdominal pregnancy, as the placenta nor its remanent were seen in the peritoneal cavity or other viscera, moreover the ultrasound on 30.04.97 had documented it to be intrauterine pregnancy. It was not a case of hetrotopic pregnancy as it was the same intrauterine foetus which was reported by ultrasound and was recovered from the abdomen after its extrusion from the uterus, nor it could be a case of superfoetation or superfecundation.

REFERENCES

1. Hammond B, Charles, Bachus E Kevin. In ectopic pregnancy. Danford's Obstetrics and Gynaecology seventh edition 187.
2. Ectopic pregnancy. Novak's Textbook of Gynaecology 496.
3. Droegemueller William, et al. Ectopic pregnancy comprehensive Gynaecology. 406.
4. Gompel Claude, Silverberg Steven. Ectopic pregnancy pathology in Gynaecology and Obstetrics. 372.