Case Report

Pregnancy without uterus - a case report

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Abstract

We report the case of a 34 year old multiparous lady who presented to emergency department with acute abdomen and bleeding pervaginum, six months after total hysterectomy. On ultrasonologic evaluation, a live ectopic pregnancy of 14 weeks with hemoperitonium was detected and this was confirmed and managed by emergency laparotomy. High degree of suspicion is required for the diagnosis of abdominal pregnancy after a total hysterectomy to avoid delay in treatment.
Key words: abdominal pregnancy, ectopic pregnancy, total hysterectomy.

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INTRODUCTION

Ectopic pregnancy after hysterectomy [1-4] is a rare clinical presentation that is potentially life threatening to the mother which needs early diagnosis and prompt treatment. This is possible if the fertilized ovum is in the fallopian tube at the time of the hysterectomy or if a fistulous tract exists between the vagina and the ovaries, facilitating fertilization.[1] Delay in diagnosis can lead to catastrophic hemoperitonium which may end fatally.

CASE REPORT

A 34-year old multiparous lady who underwent hysterectomy six months back for fibroid uterus was referred to our hospital with complaints of pain abdomen and bleeding per vaginum of two days duration. She had an episode of bleeding per vaginum two months back which was managed conservatively at a local hospital. On examination, she had pallor and tachycardia. There was abdominal distension with diffuse tenderness, guarding, rigidity, rebound tenderness and shifting dullness. Perspecula examination showed tube like tissue on the vault. There was tenderness and fullness of the vault. Emergency ultra sound revealed a live ectopic gestation with biparietal diameter of 14 weeks of gestational age along with placenta in the pelvis. There was also gross intra peritoneal collection. She was immediately taken up for emergency laptrotomy under GA. Abdominal cavity contained 3 litres of blood. The foetus was lying in the peritoneal cavity close to the vault. Membranes were absent. Placenta was attached to the sigmoidal colon posteriorly and to the vault anteriorly with active bleeding from its attachments. The placenta was removed in toto from the attachments (Fig. 1). The part of the sigmoidal colon adherent to placenta was unhealthy, avascular, with a perforation so that the segment was resected with end to end anastomosis. The left ovary and fallopian tube were removed along with that. Right ovary was not visualised due to adhesions. Hemostasis was achieved. Six units of PRC and four units of FFP were transfused. Tube attached to the vault was resected and vault repair was done.

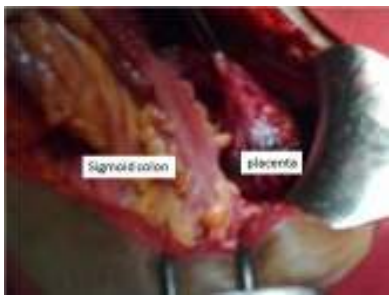

Figure 1: Separating placenta from sigmoid colon

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Post operative period was uneventful and she was discharged on day 15.

HISTOPATHOLOGICAL REPORT

Histopathological report shows syncytiotrophoblastic cells and foreign body giant cells on the serosal surface of resected segment of colon, other pieces received shows decidual tissue with chorionic villi, fallopian tube and ovarian tissue showing corpus luteum (Fig. 2).

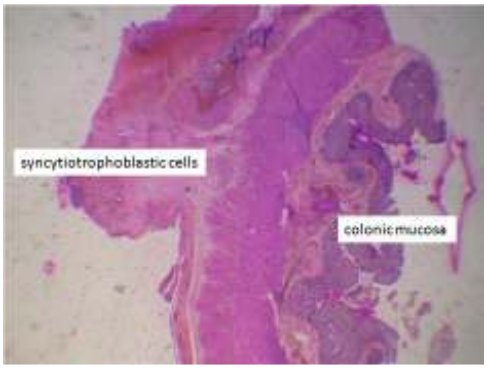

Figure 2: Histopathological specimen showing syncytiotrophoblast on colonic serosa (H& E stain- 400x)

DISCUSSION

Abdominal pregnancy is a rare form of ectopic pregnancy. It forms only 1% of all ectopic pregnancy. It is lethal to both mother and foetus associated with high morbidity and mortality. Ectopic pregnancy after hysterectomy is a still rare event. Only 56 cases of ectopic pregnancy after hysterectomy have been reported in the review of literature.[5] 31 cases were early presentations i.e. they occurred in the immediate period following hysterectomy and these pregnancies were presumed to have been present at the time of hysterectomy.[1-4] Late presentation ectopic pregnancy formed the rest and they developed as a result of communication between vagina and peritoneal cavity. This case is thus presented because of its rarity. Here the tissue which was visualised in the vault was the prolapsed fallopian tubes through which the connection between the vagina and abdomen was made thus facilitating fertilization. A detailed evaluation of this patient at the time of her previous bleeding per vaginum two months back could have prevented this life threatening acute condition. Thus in a reproductive aged woman, who has undergone hysterectomy it is important to consider ectopic pregnancy as a differential diagnosis when she presents with pain or bleeding per vaginum.

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