CASE REPORT

SPLENIC RUPTURE MASQUERADING RUPTURED ECTOPIC PREGNANCY

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ABSTRACT:

Ectopic pregnancy has been described as a 'great masquerader'. It mimics virtually every condition that causes acute abdomen in women of reproductive age group. The classical triad of presentation of delayed menses, irregular vaginal bleeding and abdominal pain may not be encountered at all!

Overwhelming features of abdominal pain, amenorrhea, pallor, abdominal tenderness, shifting dullness with positive pregnancy test gave a clinical diagnosis of ruptured ectopic pregnancy.

At laparotomy, an intrauterine gestation with normal tubes and ovaries with complete splenic rupture were found. She had total splenectomy.

CASE HISTORY:

Mrs. L.P, a 27 year old gravida 5 para 3 + 0,3 alive. Her last menstrual period was? 11,03, expected date of delivery was? 8.04, with an estimated gestational age of? 14 weeks, Her last delivery was 3 years earlier.

She presented to the gynaecological emergency unit of Jos University Teaching Hospital, Jos following a referral with a one-day history of lower abdominal pain, profound dizziness and collapse. The abdominal pain was severe, first on the left hypochondrium then to the lower abdomen. There was associated shoulder tip pain. No fever or vomiting and no vaginal bleeding. She denied any battering or trauma, apart from the fall when she felt dizzy and collapsed.

Clinical examination revealed an ill looking young woman that was severely pale, afebrile (temperature of 36.5^0c) and dehydrated.

Her pulse rate was 108 beats per minute, regular, small volume. Blood pressure was 90/60mmHg and respiratory rate of 28 cycles/min.

Her abdomen was distended with generalized abdominal tenderness, guarding and rebound tenderness. There was shifting dullness with hypoactive bowel sounds. Pelvic examination showed a normal vulvovagina. The cervix was closed with cervical erosion. Uterine size could not be delineated because of tenderness. Adnexae were tender with fullness of the pouch of Douglas. No blood was seen on examining finger. Urine pregnancy test was positive. Packed cell volume at presentation was 23%. Urea and electrolyte were within normal limits.

Based on history of? 14 weeks amenorrhea, dizziness and sudden collapse with lower abdominal pains, shoulder trip pain with findings of severe pallor, generalized abdominal tenderness with shifting dullness and a positive pregnancy test, a clinical diagnosis of ruptured ectopic gestation was entertained.

She was resuscitated with intravenous normal saline 2 litres. Four units of blood was grouped and crossmatched. She had emergency laparotomy.

At laparotomy findings were, normal tubes and ovaries, bulky uterus about 14 weeks suggestive of intrauterine gestation, haemoperitoneum of 2.0 litres and a complete splenic rupture. She had drainage of haemoperitoneum and total splenectomy, thereafter had peritoneal lavage with 2 litres of warm Ringer's lactate.

She had 3 units of O rh-positive whole blood transfused. She did well postoperatively with a postoperative packed cell volume of 29% by the third day. She had no vaginal bleeding. Stitches were removed on the 7th postoperative day. She had a pelvic ultrasound, which showed 14 weeks intact intrauterine gestation. She was discharged home to book for antenatal care.

DISCUSSION:

The ease with which the diagnosis of entopic pregnancy could be missed with consequent morbidity and mortality because of it's varying presentation has made gynaecologist to tag it "the great masquerader".[1] This has made clinicians to be cautious and be suspicious of any woman of reproductive age group presenting with a history of lower abdominal pain.[2] Here is a case with overwhelming features of a ruptured ectopic gestation, which turned out to be complete splenic rupture, which may have, followed a domestic fall when she felt profoundly dizzy. Surprisingly, the splenic size was normal, however spontaneous rupture of the normal spleen in pregnancy has been occasionally documented in literature.[3]

For a complete rupture, it was expected that a severe form of trauma would have been

implicated as in battering, this patient denied such a history even though it is still on contention, as most women will conceal a history of domestic violence in pregnancy[4] Large size spleens are known to silently rupture[5]. Splenic ruptures following trauma from road traffic accident or severe falls are common[5]. Ectopic pregnancy is one of the commonest gynaecologic emergency encountered in our practice. The incidence in our centre is 1.58%[6]. It is also one of the commonest female surgical emergencies. Forty percent of ruptures are known to be acute with sudden onset of pelvic pain with rapidly deteriorating clinical condition because of intra-abdominal bleeding[5,7] This bleeding when severe tracks along the paracolic gutters irritating the diaphragm giving rise to shoulder tip pain as in this case.

The incidence of ectopic pregnancy is known to be higher in developing countries as opposed to the developed nations even though it varies from country to country[2,7,8] Exploratory laparotomy should be performed whenever a clinical suspicion is overwhelming. Pelvic ultrasound and laparoscopy may be done where features are less obvious. A splenic rupture is a rare differential diagnosis of ectopic pregnancy. This is the first of such case in our centre.

This case call for scrutiny of clinical diagnosis in ectopic gestation in contemporary gynaecological practice. It is advised that all causes of acute abdomen in women must be borne in mind when there is a suspicion of ectopic pregnancy. For it is better to suspect ectopic pregnancy than to miss it!

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