nusual Cases

FULL-TERM TUBAL PREGNANCY WITH RETENTION OF SKELETON FOR TEN MONTHS

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e term extra-uterine pregnancy is always used in a ad sense and not only includes tubal, abdominal, ovarian l cervical pregnancies, but also those situated in the erstitial portion of the tube, and in a rudimentary horn the uterus.

t is estimated that ectopic pregnancies occur once in ry 250 - 300 pregnancies, and that about 95% are tubal. On reading the literature the conclusion is reached that s the remaining 5% of extra-uterine pregnancies that e the greatest difficulty in diagnosis. This is especially when the foetus is viable, and the true nature of many these cases can only be discovered after various methods induction have failed and where an operation is ultitely performed.

There have been many reports in the literature of extraine pregnancies which were not diagnosed and where foetus and foetal parts were carried for long periods, there are very few reports of a full-term tubal pregncy carried for a long time. The details of such a case reported here.

CASE REPORT

Bantu woman of about 39 years, para 3, was admitted to Klerksdorp Hospital on 27 September 1960, with the gnosis of acute intestinal obstruction. She was in a state of lapse, very dehydrated and shocked, and was too weak to e any relevant history. In a letter which accompanied her, vas stated that she had had no motions for 3 days, and that vomited a great deal and complained of generalized dominal pain, which was colicky in nature.

amination

She was a thin Bantu woman, very dehydrated and colsed. Her general condition was poor, her pulse weak, and blood pressure 110/90 mm.Hg. Her abdomen was disded and very tender, making a satisfactory examination nost impossible. Fluid could be detected in the abdominal ity, but there were no bowel sounds. Vaginal examination s painful and revealed a large hard mass in the pelvis. ere was a vaginal discharge.

A straight X-ray of the abdomen demonstrated a completely articulated skeleton in the pelvis (Fig. 1).

eration

After intravenous infusions were administered her condition proved and a laparotomy was performed. On opening the domen a fibrinous peritonitis with loculated free fluid was ind. The adhesions were easily undone and the fluid acuated. An indiscernible hard mass was present in the ivis, and after careful examination it was possible to monstrate a small uterus, an oedematous, distorted left pe and a grossly enlarged right tube with skeletal contents g. 2). A hysterectomy was performed; the patient made an eventful recovery, and was discharged 7 days after the eration.

On opening the right enlarged tube, a complete disarticulated, l-term skeleton, devoid of any soft tissue, was found. All bones could clearly be identified, as shown in Fig. 3 ere the skeleton has been reconstructed.

story

Three days after the operation, the following history was cited. Her last menstrual period was in February 1959. out May 1959 she started bleeding, felt sick, and had pain

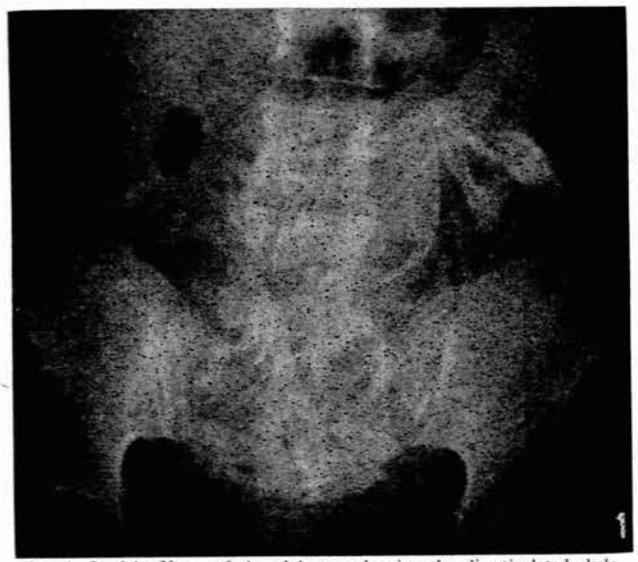

Fig. 1. Straight X-ray of the abdomen showing the disarticulated skeleton in the pelvis.

in her right side. She visited her doctor who told her it was impossible to say whether she was pregnant. She received an injection and had to report back again, which she did not do. For 3 months she had a slight daily haemorrhagic discharge. Since then she was well, felt life, but had no notion whatsoever of any dates and months, and to use her own expression, 'she felt life for the last time when the green mealies ripened', which must have been towards the end of November, or the beginning of December 1959. She was able to carry on with her usual duties, and felt well until 3 days before admission, when she experienced vague abdominal pains. These became steadily worse, and she started vomiting the next day. Her abdomen felt full, the pain became excruciating and she had no motions. She felt very weak and could not remember what happened after that. She was seen by the District Surgeon, who diagnosed acute obstruction and had her transferred immediately to hospital where she arrived in the state described above.

REVIEW OF THE LITERATURE

Aschman and Helwig[1] reported 2 cases of long-retained extra-uterine pregnancy, one possibly of 35 years' duration and removed in a woman of 69 years during an exploratory operation for cancer of the stomach. The tumour proved to be an extra-uterine pregnancy with well-formed skeletal parts. The second case was 6 months overdue, but was erroneously diagnosed clinically and on X-ray as an intrauterine pregnancy. An operation performed 6 months after the expected date of delivery proved it to be an extrauterine pregnancy.

Charlewood and Culiver[2] gave a résumé of 52 cases of advanced extra-uterine pregnancy. Only 12 were diagnosed correctly where the foetus was alive. Their cases prove the difficulty in making a correct diagnosis even where all facilities are available. In Cullingworth's case[3] the diagnosis

of an advanced extra-uterine pregnancy where the child was living, was made only after the patient was admitted to hospital for the second time.

Fenwick[4] reported a case of a woman of 45 years, who retained a 5 months' foetus in the left tube for a number of years. The tubal pregnancy started to suppurate, became adherent to the hollow viscera, and ultimately perforated into the bladder and sigmoid colon. The patient died after laparotomy.

In Lakhoti's case[5] there was a history of 10 months' pregnancy, and 20 days before admission the patient had an acute pain in the back, followed by a watery vaginal discharge. She also had a wound below the umbilicus from which pieces of foetal bone were discharged. When these pieces were removed it was found that the wound communicated with the vagina. This was apparently a case where a dead foetus was retained in the uterus, and sloughed through to the abdominal wall. The patient died.

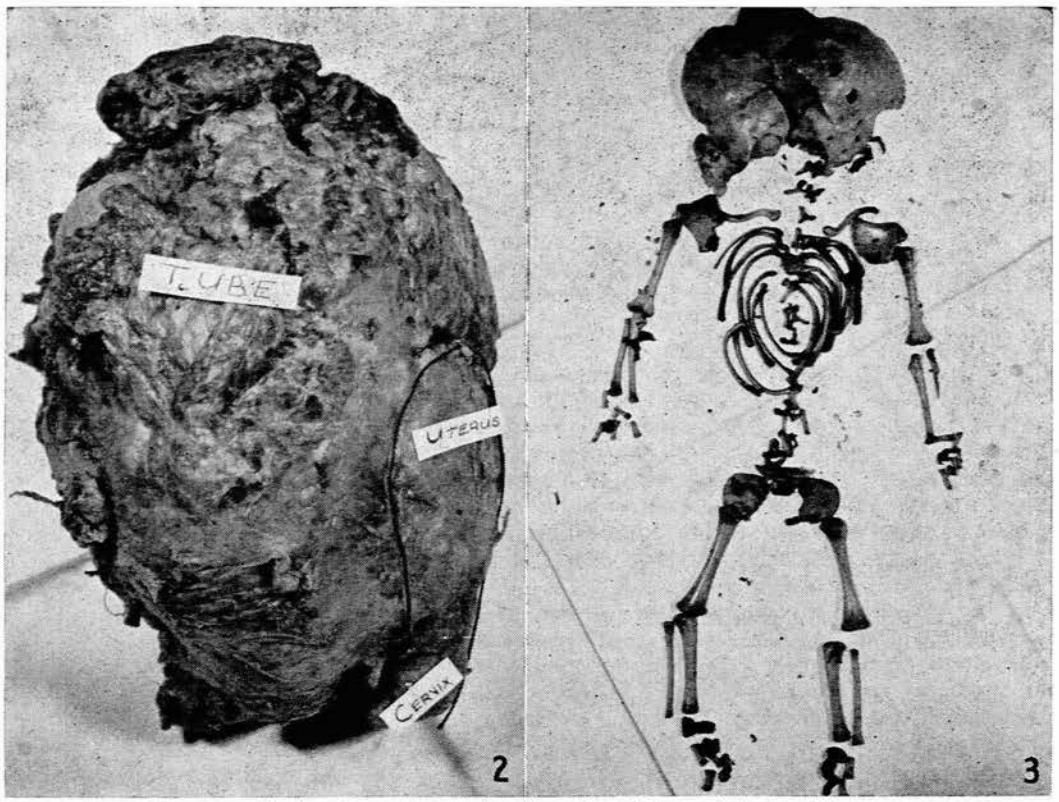

Fig. 2. Showing the uterus and the right tube which contained the skeleton.
Fig. 3. The reconstructed skeleton removed from the tubal sac.

Payne[6] described a case of a woman aged 30 years, who carried the dead foetus in an extra-uterine pregnancy for many months. The patient was operated on and a sac containing foetal tissues was removed. The patient made a good recovery.

In the case described by Temple and Hester[7] a living foetus was found in the left tube and a smaller foetus in the right tube. Further, a partially calcified lithopedion was also found in the upper abdomen.

Viduya and Orencia[8] reported a case of a woman of 60 years, where foetal bones were removed from the urinary bladder, and loose bones were found penetrating through the upper, left posterior fundus. The patient made an uneventful recovery. It was estimated that she carried these products of conception in the urinary bladder for about 26 years. Following this abdominal pregnancy and while carrying the foetal bones, she delivered herself spontaneously of a full-term infant.

Williams[9] described a case of a 30-year-old mother in whom a skeletonized foetus was removed from the abdomen. Before the operation she began to pass small pieces of bone per vaginam through a uteroperitoneal fistula, as was demonstrated at the operation.

SUMMARY

A case is reported in which a tubal pregnancy in a Bantu woman developed to full term. The child died and disintegrated completely, leaving only the skeleton in the tubal sac. Ten months after the foetal death the patient presented with an acute obstruction, resulting from a fibrinous peritonitis with massive adhesions. A correct diagnosis was only made at operation, when the uterus and the tube containing the skeleton were removed. The patient made an uneventful recovery.

OPSOMMING

'n Geval van 'n Bantoevrou wat 'n voltydse buisswangerskap ontwikkel het, word hier gerapporteer. Die fetus het gesterf, en het heeltemal gedisintegreer, met die gevolg dat die hele skelet in die buis gebly het. Tien maande na die fetale dood is die pasiënt tot die hospitaal toegelaat met 'n akute obstruksie as gevolg van 'n fibrineuse peritonitis met menigvuldige vergroeiings. Die ware diagnose is eers gemaak nadat 'n laparotomie uitgevoer is, en die baarmoeder saam met die buis bevattende die skelet verwyder is. Die pasiënt het volkome herstel.

I am indebted to Dr. H. H. Siertsema, Medical Superintendent of Klerksdorp Hospital, who did special duty when the patient was admitted, and who was responsible for getting the patient into a fit state for operation. Thanks are also due to Dr. D. Fourie for the photographs.

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