

# Lithopedion coexisting with a huge uterine fibroid: A case report

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### ABSTRACT

A lithopedion (stone baby) is a rare phenomenon seen in advanced abdominal pregnancy. There are few cases reported in Africa. This is a case report of a 50-year-old woman who presented with a complaint of an abdominal swelling for 15 years. She was suspected to have a uterine fibroid. She was subsequently prepared for myomectomy. Intraoperatively, she was found to have a calcified intact fetus with a coexisting huge uterine fibroid. She had extirpation of the calcified fetus and myomectomy. She did well postoperatively and was discharged home on the 7<sup>th</sup> day.

**Key words:** Abdominal pregnancy; lithopedion; uterine fibroid.

### Introduction

Abdominal pregnancy occurs as a result of tubal abortion or rupture. It is often undiagnosed especially if the pregnancy is not booked early. It is often associated with significant maternal morbidity and mortality because of intraabdominal hemorrhage and sepsis.<sup>[1]</sup> Fetal complications are not uncommon and they occur because of poor placentation since the placenta implants in the abdominal cavity.<sup>[1]</sup> Consequently, poor nutrients and oxygen supply result into chronic hypoxia, severe growth restriction, anomalies, and fetal death. If undiagnosed, it may become calcified to form lithopedion, (litho = stone; pedion = child). It occurs in upto 1.8% of abdominal pregnancies.<sup>[2]</sup>

### Case Report

The patient was a 50-year-old Para 6<sup>+1</sup> A3 who was referred from a peripheral clinic with a 15-year history of abdominal swelling. There was no history of heavy menstrual bleeding, dysmenorrhea, or dyspareunia and no urinary symptoms.

The mass appeared after her last pregnancy 15 years prior to presentation. There was no antenatal care for the pregnancy and no ultrasound was done to confirm the pregnancy. She thought she was pregnant after she missed her period for about 5 months. Although there was neither miscarriage nor delivery of the pregnancy, she however resumed menses at the 7<sup>th</sup> month. Abdominal enlargement gradually decreased thereafter. The abdominal enlargement then reoccurred gradually over 15 years. There was associated discomfort and easy satiety. She had no family history of ovarian, endometrial, or colonic cancer. She attained menarche at the age of 13 years and she was not formally educated.

All her pregnancies were not booked and she had unsupervised home deliveries. The first pregnancy ended as a spontaneous miscarriage. There was no dilatation and curettage done for

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her. She had four children alive (two males and two females). She was not aware of any form of contraception and Pap smear.

She was found to be a middle-age woman who weighed 57 kg. She was not febrile (temperature 37.4°C), not pale, anicteric, acyanosed, and had no pedal edema. Her pulse rate was 86 beats/min and the blood pressure was 110/60 mmHg. Her respiratory rate was 18 cycles/min and breath sound was vesicular. There were first and second heart sounds. The abdomen moved with respiration and there was a pelvic fullness. There was a firm, mobile pelvic mass, about 20 weeks uterine size that was smooth and nontender. The liver and spleen were not palpably enlarged while the kidneys were not ballotable. Pelvic examination revealed a normal vulva and vagina. The cervix was grossly normal on speculum examination. It measured about 2.5 cm and the cervical Os was closed. The pouch of Douglas was full with a hard mass, nontender. The cervix moved with the pelvic mass.

A diagnosis of uterine fibroid was made with a differential of an ovarian tumor. She was counselled on her condition and investigations were requested. The PCV was 31%, WBC  $6.8 \times 10^9/L$ , and the platelet count was  $280 \times 10^9/L$ , Ca 125 was 5 miu/L. The liver and renal function tests were essentially normal. Two units of blood were cross-matched for her. A transabdominal ultrasound showed a uterine mass that has a heterogeneous echogenicity in the fundus and a dense echogenic mass in the posterior uterine wall measuring  $17 \times 15 \times 10$  cm. The endometrial plate was thin. The ultrasound suggested a calcified uterine fibroid.

The patient was counselled on the finding of the ultrasound and the need for an abdominal myomectomy which she consented for it.

The intraoperative findings were grossly enlarged uterus. A subserosal uterine fibroid was found on the posterior-fundal region of the uterus. A calcified fetus enveloped by the omentum was found lying longitudinally posterior to the uterus. There were mild bowel adhesions. The tubes and ovaries were grossly normal and estimated blood loss was about 100 mL.

She had extirpation of the calcified well-conserved fetus and myomectomy [Figures 1 and 2]. Patient did not have any blood transfusion and the procedure was well tolerated. Her postoperative condition remained stable and she was discharged on the 7<sup>th</sup> day with no complaint.



Figure 1: Lithopaedion removed during myomectomy

## Discussion

Abdominal pregnancy is often classified as primary or secondary abdominal pregnancy.<sup>[3]</sup> The clinical relevance of this classification may not be important since the clinical course and management for both types is the same. There are cases of abdominal pregnancies reported to be coexisting with uterine fibroid.<sup>[3]</sup> However, literature search revealed no similar case was reported in our subregion.

Risk factors associated with abdominal pregnancy are those found in ectopic pregnancies, such as previous history of ectopic pregnancy, pelvic inflammatory disease, tubal surgery, congenital and acquired uterine anomalies, and endometriosis.<sup>[3]</sup> The risk factor found in this patient was history of spontaneous miscarriage which may be complicated by subclinical infection and uterine fibroid. This patient was not formally educated and therefore poor health-seeking behavior has contributed to her late presentation.

Diagnosing abdominal pregnancy always poses a challenge to clinicians because of vague symptoms and late presentation.<sup>[4]</sup> However, that depends on the gestational age at presentation. With early pelvic ultrasound scan, it can easily be detected while in late presentation, easily palpable fetal parts may give a high index of suspicion clinically. Improved resolution of modern ultrasound machines and the availability of computed tomography scans (CT scan) and magnetic resonance imaging (MRI) have eased the management of ectopic pregnancy. These also made the incidence of advanced abdominal pregnancy to decline because of early diagnosis and treatment. In the index case, the abdominal pregnancy was missed because of its proximity with a coexisting uterine fibroid and poor health-seeking behavior of the woman.



Figure 2: Lithopaedion with the huge fibroid after myomectomy

The demise of an abdominal pregnancy less than 14 weeks of gestation is usually reabsorbed by the maternal body.<sup>[5]</sup> However, beyond 14 weeks of gestation, fetus may be too large to be absorbed by the maternal body, it will therefore calcify on the outside as part of a foreign body reaction, shielding the mother's body from the dead tissue of the fetus and preventing infection.<sup>[5,6]</sup> A calcified fetus in the abdomen can have the following forms: (1) lithokelyphos (litho = rock, kelyphos = shell): only the ovular membrane is calcified and the fetus can be in different stages of decomposition; (2) lithokelyphopedion: both are calcified, that is, fetus and ovular membrane; (3) lithopaedion: only the fetus is calcified as in this case.<sup>[7]</sup>

The lithopaedion may stay with the mother for many years until during an evaluation or surgery for it to be discovered. It often presents as an abdominal (umbilical) fistula discharging fetal bones.<sup>[4]</sup> The index case did not have umbilical fistula.

The treatment of an advanced abdominal pregnancy is surgical. The index case had adhesiolysis, extirpation of the lithopaedion, and myomectomy. Her postoperative period was satisfactory.

## Conclusion

A lithopaedion is a very rare outcome of ectopic pregnancy. With the availability of advanced diagnostic facilities, high index of suspicion is needed to aid diagnosis and treatment. Poor education, late presentation contributed to neglecting the abdominal pregnancy although there was no complication recorded.

## Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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## Conflicts of interest

There are no conflicts of interest.

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