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Case Report

A case report on broad ligament pregnancy

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ABSTRACT

Broad ligament pregnancy is a rare type of ectopic pregnancy but life threatening condition. Here, we are describing a case of primary broad ligament pregnancy which is diagnosed only on exploratory laparotomy but clinical examination as well as ultrasound didn't help us to diagnose this case.

KEYWORDS: Broad ligament, pregnancy

INTRODUCTION

Ectopic pregnancy is type of pregnancy in which the fertilized ovum is implanted and developed outside the normal endometrial cavity. Ectopic pregnancy in broad ligament is a retroperitoneal abdominal pregnancy, in which the fetus or gestational sac develops within the leaves of the broad ligament[1]. It may occur in any part of the abdomen but it is common in pouch of Douglas and is rare in broad ligament[2].The pregnancy following tubal rupture going in the broad ligament is called secondary broad ligament pregnancy. Primary broad ligament ectopic pregnancy is a rare event when pregnancy occurs within the broad ligament itself[3]. Here, we are describing a case of primary broad ligament pregnancy which diagnosed only on laparotomy.

CASE REPORT

We are reporting case of a 25 year's old female who is $G_5P_2L_2A_2$ with 22 weeks 6 days gestation, reported to the emergency department with pain in lower abdomen and fever. Patient brought two USG reports with her. One showed single intrauterine dead fetus of 18 weeks 1 day with low lying placenta and another USG showed Bicornuate uterus with fetus is in right cornu with low lying placenta.

On examination the patient was hemodynamically stable but febrile. Uterine size was 20 weeks which was not tense and tender. Repeat USG done in our institution and it showed single non-viable pregnancy of gestational age 16 weeks 2 days on right side of uterus surrounded by a pocket of fluid –pregnancy in any congenital anomalous uterus-?one of the cornua of bicornuate uterus ?? Extra uterine pregnancy.

Patient was immediately taken for laparotomy which revealed large tense cystic elongated mass of size 20 X 12 cms arising from right side of Broad ligament and it was reaching up to right flank (Figure1).

On the left side of mass Uterus was around 12weeks size. Bilateral tubes and ovaries were normal looking. A small incision given on the sac and foul smelling dark reddish coloured fluid was drained out and a macerated dead fetus of around 20-22weeks size was delivered out (Figure 2). Parts of the placenta was taken out and rest of the placenta was not possible to remove. Marsupialization of the edges was done. Drain was kept and abdomen was closed in layers.

During the post-operative period there was about 200- 300 ml of copious bloody serous discharge present, which gradually reduced over a period of one month. Rest of the post-operative period was uneventful.

Figure 1: Showing a large tense cystic elongated mass of size 20 X 12 cms (approx.) arising from right side of Broad ligament

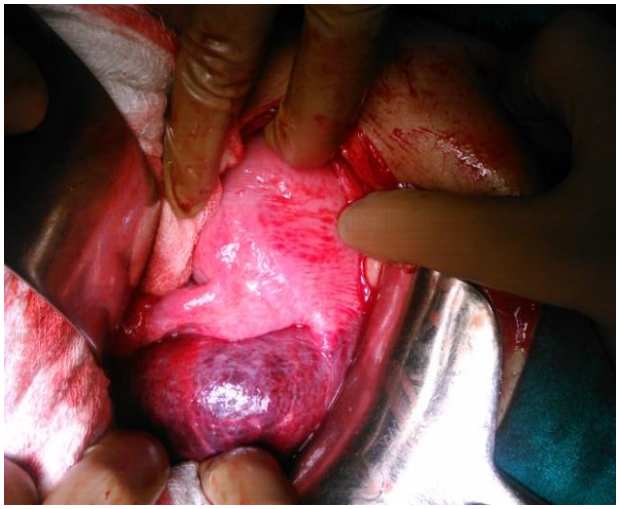


Figure 2: Showing a macerated dead fetus of around 20-22weeks size



DISCUSSION

The maternal mortality rate has been reported to be as high as 20%[4]. This is primarily because of the risk of massive hemorrhage from partial or total placental separation. The placenta can be detached at any time during pregnancy leading torrential blood loss. Primary abdominal pregnancy where the fertilized ovum gets implanted into the abdominal cavity is very rare[5]. Secondary abdominal pregnancy occurs in Ovary, pouch of Douglas, broad ligament, liver, spleen and sigmoid colon[6].

There is difference in the clinical presentation of abdominal and tubal pregnancy. Though the triad of ectopic pregnancy is amenorrhea, abdominal pain, vaginal bleeding, there are various clinical presentations reported in the literature but a dull lower abdominal pain during early gestation is common[7]. Here, the patient presented with pain in lower abdomen and fever. Vaginal bleeding is also common feature reported in half of the patient and it is due to break down of decidual cast[8].

Ectopic pregnancy can have a varied outcome. Mostly it remains dormant, it can also miscarriage, rupture intraabdominally or extend into the broad ligament. In literature, a few cases have been reported where such pregnancies reached term and even with live birth of baby delivered by laparotomy[9]. The diagnostic investigations namely β-HCG, transvaginal ultrasound (TVS), laparoscopy are mandatory[1]. Whenever the HCG is more than 1500 IU per ml, by TVS a gestational sac should be seen in the uterus, when the HCG is more than 6000 IU per ml, it is possible to see gestational sac by trans-abdominal route. When gestational sac is missing ectopic pregnancy is kept in mind. This is the discriminatory zone. The most important factor is doubling of HCG in 48 hrs. is noted in non-viable intrauterine and ectopic pregnancy. Laparoscopy is the gold standard in the diagnosis of unruptured ectopic. But in hemodynamically unstable patients only laparotomy is mandatory.

CONCLUSION

This case of broad ligament ectopic pregnancy is reported here not only because of its rarity but also the diagnosis is a challenge. Early diagnosis of intrauterine pregnancy and excluding extrauterine pregnancy is very important when woman comes for confirmation of pregnancy at her first antenatal visit. Early diagnosis and prompt surgical intervention definitely improves the morbidity and mortality in patients with abdominal ectopic pregnancy.

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