

Extra-uterine pregnancy communicating with the bladder

A case report

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Summary

A young woman presented 5 months after her last normal menstrual period with a history of having passed a macerated fetal limb during micturition. She had a pelvic mass which was found at laparotomy to be due to a ruptured infected extra-uterine pregnancy. This lay in the uterovesical pouch and communicated with the bladder.

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Case report

The patient was a 22-year-old Black woman who had had one previous normal pregnancy. Her last normal menstrual period had been in April 1981, and she said that she had been in another hospital during most of September with a diagnosis of threatened abortion.

She presented on 29 October complaining of lower abdominal pain and brought with her a macerated fetal limb which she said she had passed during micturition. Her temperature was 38°C, and the pulse rate and blood pressure were normal. She had a pelvic mass reaching to just below the umbilicus. Vaginal examination revealed a white discharge; the cervix was closed with no trace of bleeding.

Laboratory investigations revealed a haemoglobin concentration of 8,5 g/dl and a white cell count of 11 000/ μ l; urine micro-

scopy revealed 10 leucocytes and more than 200 erythrocytes per high-power field. Culture of a urine specimen showed a bacterial count of more than 10 million organisms per millilitre, and produced *Escherichia coli* sensitive to a nitroxioline-sulphamethizole-pyridoxine combination, nalidixic acid and nitrofurantoin. The blood urea value was 2,0 mmol/l. A pregnancy test was not available. Radiographs of the chest and abdomen were normal.

The patient was transfused with 3 units of packed cells and scheduled for laparotomy the next day. At operation the right fallopian tube was found to be enclosed in a chronic infected haematoma, the lining of which was related to the anterior surface of the uterus, the bladder and the right external iliac blood vessels. When evacuated the haematoma cavity was found to contain the remains of a macerated fetus and was connected to the bladder by a fistula 1 cm in diameter. A piece of fetal limb was found in the bladder. The left adnexum was normal. A right salpingectomy was performed and the haematoma lining stripped from the bladder to expose the fistula. This was closed with three invaginating 2/0 extrachromic catgut sutures. A de Pezzer catheter was inserted through the bladder fundus, a drain was inserted into the pouch of Douglas, and the abdomen was closed. A self-retaining catheter was left in the bladder.

Postoperative treatment included the use of intramuscular chloramphenicol and intravenous penicillin. On the 3rd day these were given orally together with metronidazole for 1 week. The patient remained pyrexial, with a temperature of about 38°C; her pulse rate reached 130/min. The white cell count reached 24 000/ μ l on the 2nd day. These parameters all returned to normal by the 15th day. Apart from a small leak of urine through the drain on the first day, she remained dry. The suprapubic catheter was removed on the 13th day and the urethral one on the 17th. The patient was discharged well 3 days later on a course of nitrofurantoin.

The pathologist reported the presence of blood clot and remnants of fallopian tube and a macerated fetus roughly 12 cm long. Histological examination showed the fallopian tube to be the seat of a fairly florid inflammatory process. Among the blood clot there were islands of degenerate-looking placental tissue.

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