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Live abdominal pregnancy presenting as massive rectal bleeding

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Summary: A case of massive rectal bleeding resulting from the placental attachment of an abdominal pregnancy to the sigmoid colon is reported. Both mother and infant survived this rare complication which should be considered when abdominal colic and major gastrointestinal haemorrhage occur in a pregnant patient.

Introduction

Abdominal pregnancy comprises 1.6% of all ectopic pregnancies. Only 25% diagnosed after 20 weeks of gestation have viable pregnancies and one third of these babies will be deformed (Strafford & Rogon, 1977). Extra-uterine pregnancy may cause intestinal or ureteric obstruction, and may be further complicated by infection with abscess formation and, if separation of the placenta occurs, with intra-abdominal haemorrhage. We present what we believe to be the first report of massive gastrointestinal haemorrhage due to erosion of the placenta into bowel – with survival of mother and child.

Case report

A 29 year old pregnant female presented with a 1 day history of lower abdominal cramps and the passage of blood per rectum. She had received no prior ante-natal care and had no previous medical history of note. Examination revealed an anaemic (haemoglobin 6 g/dl) woman with a viable 34 week fetus. After transfusion she underwent gastroduodenoscopy which failed to detect any abnormality in the upper gastrointestinal tract. However, following the procedure she experienced massive rectal bleeding. Sigmoidoscopy demonstrated brisk arterial haemorrhage at 15 cm. At laparotomy an extra-uterine pregnancy was found lying posterior to a 12 week size uterus. A live 2.2 kg infant was delivered. The placenta was found to have eroded into the sigmoid colon with most of it attached to the mesocolon and posterior wall of the uterus. The sigmoid colon with a large proportion of the placenta attached to its mesocolon was resected, followed by an end-to-end anastomosis and a covering proximal loop colostomy. The post operative course was complicated by a pelvic abscess which was successfully drained. Following this she made a rapid recovery and subsequently had an uneventful closure of colostomy. The child showed no signs of distress at birth and has done well, apart from one transient febrile episode in the neonatal period. To date no obvious congenital abnormalities have been detected.

Discussion

Erosion of the placenta into bowel in abdominal pregnancy causing massive gastrointestinal haemorrhage has been reported on five previous occasions but in none of these cases has the pregnancy been viable, and in only two instances have the patients survived (Bigg & Jarolim 1965; Edgar, 1901; Engel, 1961; Shirkey *et al.*, 1964; Webster & Kerr, 1956). We believe this to be the first report of both child and mother surviving this unusual complication of abdominal pregnancy. The early clinical diagnosis remains difficult as nonspecific symptoms such as attacks of diffuse crampy abdominal pain, constipation, nausea, vomiting and vaginal spotting may predominate. The patient reported here presented with an important clinical triad that should raise the suspicion of this complication, namely pregnancy, abdominal colic and major gastrointestinal haemorrhage.

Surgery in this setting is more hazardous than in uncomplicated abdominal pregnancy where the placenta can be left undisturbed even though the

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vascular supply of major organs is involved (Santos-Dias, 1971). In cases such as ours, the involved bowel with large portions of the placenta must be resected – unfortunately at the risk of further massive blood loss and potential septic complications.

Although it is tempting to proceed to further special investigations, such as sonography and angiography, to confirm the diagnosis, we believe that any delay in performing emergency surgery may have disastrous consequences for both mother and child.

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