

Primary hepatic pregnancy

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Summary: A case of a 28 weeks primary hepatic pregnancy in a 25 year old female is reported. A live male fetus weighing 1300 g was delivered after laparotomy and the placenta was left intact. The uterus was of 8 weeks size with patent tubes. The patient made an uneventful recovery.

Introduction

Primary hepatic pregnancy is a rare condition. Conclusive proof of a primary abdominal pregnancy was provided by Studdiford (1942). Cornell & Lash (1933) reported only eight cases of hepatic placental attachment in a series of 236 extrauterine pregnancies. Kirby (1969) described liver as a placental site. A lithopedion developing from a hepatic pregnancy has been reported by Luwiliza-Kirunda (1978). We report the present case because of its rarity.

Case report

A healthy 25 year old female was admitted to the surgical ward with pain and mass in the right hypochondrium for 24 weeks and burning on micturition for 4 weeks.

Abdominal examination revealed an intraperitoneal firm mobile tender mass occupying the right hypochondrium right lumbar and umbilical region. It was bimanually palpable and moved with respiration. Its upper part had a tense cystic feel while the lower part was solid. Auscultation revealed a bruit. Subsequently it was learnt that she had amenorrhoea for 28 weeks. Vaginal examination revealed a bulky 8 weeks size uterus. There was no abnormality in liver function tests; straight X-ray of the abdomen in erect posture revealed an intra-abdominal fetal shadow. A hysterosalpingogram confirmed a bulky uterus. The tubes were normal. The mass in the right hypochondrium was widely separated from the uterus.

One week after admission the patient underwent laparotomy through a right upper paramedian incision. The gestation sac was found to be adherent to the undersurface of liver. A live male fetus was delivered and the cord was ligated flush with the

placenta. The placenta was attached to the right lobe of liver and was left intact. The baby weighted 1300 g and died 30 min after delivery. Autopsy revealed no congenital anomaly. The right paramedian incision was extended downwards. The uterus was of 8 weeks size, and the tubes were confirmed to be normal as were the ovaries. Dilatation and curettage was done and histology revealed decidual reaction. The patient received methotrexate postoperatively to inactivate the trophoblastic tissue.

Discussion

Studdiford (1942) suggested four criteria for the diagnosis of primary abdominal pregnancy. (1) Normal tubes and ovaries with no evidence of recent or remote injury. (2) Absence of any evidence of uteroplacental fistula. (3) Presence of pregnancy related exclusively to the peritoneal surface. (4) The pregnancy should be recent enough to eliminate the possibility of secondary implantation following primary nidation in tubes.

All four criteria for such a diagnosis were fulfilled in our patient. In all cases of hepatic pregnancy placental attachment appears to have been to the inferior surface of the right lobe of the liver as in our case. Some patients may present with dyspeptic symptoms (Luwiliza Kirunda, 1978) due to pressure on gall bladder or duodenum. Sidall & Jarvis (1937) pointed out the value of observation of endometrial status. If the patient had been bleeding 1 week or less one could expect to find decidua without chorionic villi in 70.7%. Arias Stella (1954) described atypical endometrial changes in ectopic pregnancy.

Removal of the placenta in an abdominal pregnancy always carries the risk of haemorrhage. Moir & Myerscough (1971) strongly advise against any attempt at local removal of placenta. They recom-

mend closing the abdomen and leaving the placenta to take care of itself. Unfortunately, the placenta, if left in the abdominal cavity, commonly causes complications in the form of infection, abscesses, adhesions, intestinal obstruction, and wound dehiscence. Pritchard & Macdonald (1976) found evidence of consumptive coagulopathy, including overt hypofibrinogen-

aemia 2 months following laparotomy for delivery of the fetus. Methotrexate has been used in an attempt to inactivate the trophoblast rapidly when the placenta has been left in position (Hreshchyschyn *et al.*, 1965); and it has been suggested that it be used before operation if the baby is known to be dead.

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