Medical Memoranda

Primary Hepatic Pregnancy

Brit. med. J., 1969, 1, 296

Primary hepatic pregnancy is a rare condition. Cornell and Lash (1933), in a series of 236 extrauterine pregnancies, found only eight hepatic placental attachments. Murley (1956) in reporting a further case quoted a few others. It presents as a slow intra-abdominal haemorrhage. The onset of symptoms is confusing, and the provisional diagnoses can be misleading. A further case is reported and attention is drawn to this difficulty of preoperative diagnosis.

CASE REPORT

A 26-year-old woman was admitted to hospital with epigastric pain. For the previous three weeks she had felt unwell, complaining of shortness of breath. For two weeks she had had epigastric pain, which was relieved by food. One week before admission she had a short episode when she "went white and felt faint." Initially, the condition had been regarded as a mild cholecystitis or dyspepsia. The day before admission she had had a severe epigastric pain and again became very pale. This was followed by intermittent pain; she vomited twice but no blood was seen. Her last two periods had been a little shorter than usual. She was not taking drugs or the "pill."

On examination she was pale, but had a normal regular pulse of fair volume. The abdomen was soft and slightly tender in the upper half. Bowel sounds were heard on auscultation. Haemoglobin was 53%. A provisional diagnosis of a slowly bleeding duodenal ulcer was made; a conservative regimen was started and blood (1 litre) was transfused.

The following day the blood pressure and pulse rate were normal and stable but the haemoglobin was still 53%. A Gastrografin meal did not show an ulcer. An intravenous pyelogram was normal, but it was noticed that the hepatic flexure appeared to be displaced to the centre of the abdomen. A Gravindex pregnancy test was positive. Bimanual examination showed a slightly large uterus. Her breasts were normal.

Thirty-six hours after admission the physical signs had changed. The pulse rate had risen to 100 and the blood pressure was 105/60. The abdomen was slightly distended and there was shifting dullness to percussion. On palpation there was slight tenderness only, but no guarding or rebound. Normal bowel sounds were still heard. Despite a further transfusion of 1 litre of blood the haemoglobin level remained 53%. Laparotomy was indicated.

Operative Findings.—A right lower paramedian incision showed copious free blood and a pregnant uterus of 8–10 weeks. A large clot adherent to a hole under the right lobe of liver was felt and the incision was extended upwards. The clot had displaced the hepatic flexure of the colon downwards. The liver was compressed and the clot removed. There was a cavity 3 cm. in diameter with firm edges from which a biopsy was taken. The cavity was packed with Gelfoam, and as the liver was so friable an omental graft was placed over to hold this in situ. Deep sutures of atraumatic catgut held this graft. Haemostasis was secured.

Postoperative progress was satisfactory. The day after operation a decidual cast was passed vaginally.

Histology (Major J. B. Stewart).—Liver biopsy: products of conception; chorionic villi and trophoblast invading liver paren-

chyma. Uterine cast: complete decidual cast; no evidence of products of conception.

COMMENT

The slow onset of symptoms with minimal general and abdominal signs is as seen in tubal abortion, where it is not unusual (Hamilton Bailey, 1968). The blood loss can be slow, and haemodilution occurs to maintain a normal blood volume. Intraperitoneal bleeding following closed trauma also can show little abnormality on palpation and auscultation initially. Two recent cases seen, one a ruptured spleen and the other multiple tears of mesenteries with torn superior mesenteric artery, showed minimal tenderness or guarding, and bowel sounds were present. A high index of suspicion in a case showing progressive anaemia, with the slow onset of oligaemic shock and minimal abdominal signs, shows the need for laparotomy.

In the case reported by Mear *et al.* (1965) the pregnancy proceeded to full term and the triad of asthenia, abdominal distension, and faintness was seen, followed by sudden oligaemic shock. A full-term living infant was delivered at laparotomy (to die after 45 minutes), but the mother died after further severe haemorrhage from the liver. The haemorrhage seen in a case reported by Murley (1956) was present for at least eight hours before admission, but she had also noted epigastric discomfort, as in my patient.

The site of attachment of the pregnancy is interesting—on the inferior surface of the right lobe of the liver, and thus in relation to the Rutherford Morison pouch of the peritoneal cavity. This was the same in all three cases I have mentioned. The close relation to the gall bladder and duodenum explained the early confusing signs of dyspepsia. The menstrual history was not helpful in the diagnosis; in fact it was rather confusing.

I wish to thank Lieutenant-Colonel D. Magner, consultant gynaecologist, for his advice and assistance; and Major J. B. Stewart for his keen interest in the pathological investigations before operation and the rapid histological report postoperatively. Squadron Leader G. Haworth kindly arranged for the translation of the third reference by a member of the Canadian Contingent, United Nations Force in Cyprus, and I thank them both for their help.

NORMAN G. KIRBY, M.B., F.R.C.S.,
Lieutenant-Colonel, R.A.M.C.; Consultant Surgeon,
British Military Hospital, Dhekelia, B.F.P.O. 53.

REFERENCES

- Bailey, H. (1968). *Emergency Surgery*, 8th ed. Bristol.
- Cornell, E. L., and Lash, A. F. (1933). *Int. Abstr. Surg.*, 57, 98.
- Mear, Y., Ekra, J. B., and Raoelison, S. (1965). *Sem. Hôp. Paris*, 41, 1430.
- Murley, A. H. G. (1956). *Lancet*, 1, 994.