**CASE REPORT**

# Broad Ligament Pregnancy

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## ABSTRACT

A rare form of ectopic pregnancy can presented in broad ligament .diagnosis is often missed in these types of cases. Maternal mortality and morbidity is very high in these rare cases. Ween-countered broad ligament ectopic pregnancy with uneventful recovery.

**Keywords:** Ectopic pregnancy, Broad ligament, Ultrasound, Laparotomy.

## INTRODUCTION:

Broad ligament pregnancy account 0.001 % of ectopic pregnancies[1]. Ectopic pregnancy can occur anywhere outside the uterine cavity, common site is being ampulla of fallopian tube, but rare cases can present in pouch of Douglas, broadligament[2].

Abdominal pregnancies account for 1% of ectopic pregnancies and maternal mortality rate has been reported as high 20%[3, 4]these cases usually present with acute abdomen, but with high clinical suspicion, supplemented by ultrasound, magnetic resonance imaging MRI ,we can reach on diagnosis. Seldomly these pregnancies can reach upto term, with live baby birth.

## CASE REPORT

A 35 years female gravida 5 para 4 all alive with previous 4 caesarean section presented with history of gestational amenorrhea for 4 month, complain of vaginal spotting 5 to 6 times for 1 month and lower abdominal pain for 1 day, pain was sudden in onset, moderate to severe intensity continuous in nature dull in character and radiate toward right thigh. While her past medical family history is unremarkable. On general physical examination, her pulse rate is 120 bpm, other parameter are within normal limit. On abdominal examination tenderness is positive in right lumbar region. On per vaginal examination cervical excitation is positive, uterine size is unassessable due to her obesity. Her complete blood picture show hemoglobin 9.2gm%, other laboratory and biochemical parameter are within normal limits. On USG there was 14weeks alive ectopic pregnancy (fig .1)(most probably right tubal) seen. on CT scan report also give same result .on preoperative diagnosis of broad ligament pregnancy we did exploratory laparotomy there was severe type of adhesion found between muscle peritoneum , uterus ,tube and gut. On right side we found about 20*15cm sac containing alive fetus found in right fold of broadligament, anterior leaf of ligament opened baby along with placenta removed (fig .1), retroperitoneal clot was found near cecum that was drained with collaboration of general surgeon drain placed .her post-operative period was uneventful she discharged on 5th post-operative day and stitch removed on 10th day with contraceptive advice.

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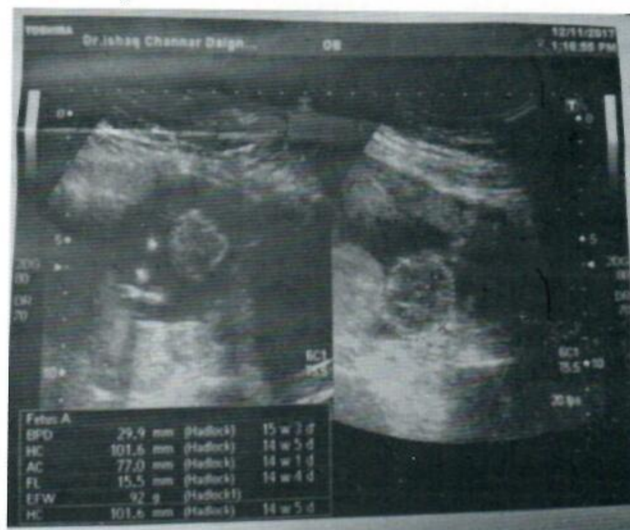


Figure I

**Figure II**

## DISCUSSION

Broad ligament pregnancy is rare form of ectopic pregnancy with high morbidity and mortality[5].it is either due to primary implantation of zygote inboard ligament or followed by secondary implantation to fallopian tube, ovary or other peritoneal surface, broad ligament, liver ,spleen, sigmoid colon.

Patient usually present with short history of gestational amenorrhea, lower abdominal pain(due to placental separation, tearing of broad ligament or peritoneal rupture)Vaginal spotting .that was common feature present in half of patient. Broad ligament pregnancy was first reported by Losche in 1816. The characteristic feature is abdominal pain precedes vaginal bleeing .the diagnostic investigations is serum B cg, transvaginal ultrasound (TVS), laparoscopy.

In normal pregnancy when Bhcg level reach upto 1500 I U per ml, gestational sac seen by trans vaginal ultrasound, when Bhcg level reach upto 6000 I U per ml ,trans abdominal ultrasound can detect gestational sac. So when gestational sac is missing ectopic pregnancy should be kept in mind. In case of ectopic pregnancy there is discriminatory zone . the most important factor is doubling of Bhcg in 48 hours is noted in a viable pregnancy. Low Bhcg level are noted in non viable intrauterine and ectopic pregnancies. Serum progesterone level below 5 ng per ml also help in diagnosis. Magneticresonanceimaging provide additional information for evaluation for extent of uterine and mesenteric involvement.

The management is exploratory laparotomy, however in patient with early gestation, haemodynimacally stable condition laparoscopic is gold standard.

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