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Secondary Abdominal Pregnancy – A Case Report

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Abstract
Abdominal pregnancy is a rare form of ectopic pregnancy with high morbidity and mortality for both mother and fetus. Diagnosis and management pose difficulties in low resource centers. A case of abdominal pregnancy revealed at the time of cesarean with live baby in our SAT hospital is presented
Keywords: *abdominal pregnancy, fetus, placenta*

Introduction

Ectopic pregnancy represents about 1–2% of all pregnancies with 95% occurring in the fallopian tube. Abdominal pregnancies represent just about 1% of ectopic pregnancies.[1] The incidence of abdominal pregnancy differs in various publications and ranges between 1: 10000 pregnancies and 1:30,000 pregnancies.[1, 2] It was reported for the first time in 1708 as an autopsy finding and numerous cases have been reported worldwide ever since. In most of these cases, the diagnosis is made on the basis of the ensuing complications such as hemorrhage and abdominal pain. Maternal mortality and morbidity are also very high especially if the condition is not diagnosed and managed appropriately. These pregnancies generally do not get to 37 weeks (term gestation) and usually the end result is the extraction of a dead fetus. Another challenge for babies from abdominal pregnancy is the very high incidence of congenital malformations.

Abdominal pregnancy at term with a healthy viable fetus is therefore an extremely rare condition and very few of such cases have been published during the last ten years. We present a case of abdominal pregnancy that resulted in a term live baby without malformations.

Case Report

34 yr old primi gravida was referred from local hospital at 31 weeks of gestation with complaints of pain abdomen was admitted on 27/7/17 in SAT Hospital. She had regular ANC at local hospital with complains of occasional pain abdomen. No history of bleeding per vaginum. She was admitted and evaluated for pain abdomen. Ultra sound had done showing a single live intra uterine fetus and central placenta previa. Placenta having features of local heterogeneous areas with placentomegaly. Her general conditions stable throughout hospital stay. She received 2 doses of corticosteroids for fetal lung maturity. The blood investigations were normal. We planned for elective cesarean at 36 weeks 6 days in view of complete placenta previa. The surgery turned out to be laparotomy with following findings. There

was greenish brown liquor in the peritoneal cavity with live abdominal pregnancy. Delivered a live female baby which was weighted 2.7 kg with apgar 9 at 1

Fig 1

Fig 2

The placenta and membrane found outside the intact uterus extending from right cornual end spreading posterolaterally to the pelvic side wall. Major chunk of placenta removed which were adherent to above sites. The right tube and ovary adherent to pelvic side wall. Left tube and ovary were normal. There was oozing from placental detachment sites, torrential bleeding controlled by pressure and haemostatic sutures. Total 5 pints packed red cell and 2 pints fresh frozen plasma given. Postoperative period uneventful. The baby was absolutely normal healthy baby with no anomalies. she was discharged on postoperative day14.

Discussion

Advanced abdominal pregnancy is extremely rare. Abdominal pregnancies are those in which implantation occurs within the peritoneal cavity excluding tubal, ovarian or intraligamentous sites of implantation. Such pregnancies are potentially life threatening with maternal mortality 7.7 times higher than that associated with intrauterine pregnancy[5]. Viable, advanced abdominal pregnancies are very rare and only a few sporadic cases have been reported in the past 10 to 15 years. In a review it is reported the incidence in 1:1320 deliveries[3] whilst some case reports cited 1:25000 deliveries.[4] Most of the cases of abdominal pregnancies are secondary from aborted or ruptured tubal pregnancy. [4] In this case it was obvious that the abdominal implantation was secondary to undiagnosed ruptured right tubal ectopic pregnancy as the placenta attached to the cornual region. Clinical diagnosis can be very difficult and ultrasound is very helpful during the early stages of gestation but can also be disappointing in the later stages.

Other radiological studies such as MRI and CT scan are helpful in the later stages.[5] it is reported even MRI played a decisive role in the diagnosis[6], unfortunately these advanced imaging technologies are not available in most parts of the third world. Our patient had five ultrasound scan examinations and none of these suggested the possibility of abdominal pregnancy. In poorly resourced centres, high index of suspicion is key for prompt diagnosis and timely intervention to prevent life-threatening complications.

In our opinion, bleeding from placental implantation site is the most life-threatening complication during laparotomy. The decision to remove the placenta or not can be a determining factor for the survival or otherwise of the woman and this decision is subject to the surgeon's expertise and the particular case in question. It is generally recommended to leave the placenta in situ and make a follow up with human chorionic gonadotropin levels.[7] In this case there was significant bleeding from some detached portions of the placenta that prompted removal of these portions to secure haemostasis. The patient was transfused with five pints of blood and 2 pints fresh frozen plasma during the operation and that

was enough. For the newborn, it is very important to rule out congenital malformations. There are reports of foetal malformations as high as 40% associated with abdominal pregnancies and only 50% of these babies survive up to one week post delivery.[8, 9]

In his extensive review, Stevens found some varying degrees of deformations and malformations in 21.4% of these infants[10]. In this case that has been presented; no malformation has been found on the child.

Conclusion

Abdominal pregnancy with resultant healthy newborn is very rare. Diagnosis of the condition can be difficult especially if the pregnancy is advanced. High level of suspicion, careful clinical and ultrasound examinations are the routine means of diagnosis though C T scan and MRI can be useful. Bleeding is the single most important life-threatening complication for the mother whilst fetal malformation is one of the problems of newborn.

Reference

1. Nwobodo EI. Abdominal pregnancy. A case report. Ann Afr Med. 2004; 3(4):195–196.
2. Badria L, Amarin Z, Jaradat A, Zahawi H, Gharaibeh A. Full-term viable abdominal pregnancy. A case report and review. Arch Gynaecol Obstet. 2003; 268(4):340–342. [PubMed]
3. Opare-Addo HS, Daganus S. Advanced abdominal pregnancy: a study of 13 consecutive cases seen in 1993 and 1994 at Komfo Anokye Teaching Hospital, Kumasi, Ghana. Afr J Reproductive Health. 2000; 4(1):28–39. [PubMed]
4. Amritha B, Sumangali T, Priya B, Deepak S, Rai S. A rare case of term viable secondary abdominal pregnancy following rupture of a rudimentary horn. A case report. J Med case reports. 2009; 3:38. [PMC free article] [PubMed]
5. Atrash HK, Friede A, Hogue C. Abdominal pregnancy in the United States: frequency and maternal mortality. Obstet Gynecol 1987; 69:333-7 5. Karat LS. Viable Abdominal Pregnancy. J Obstet Gynecol India. 2007; 57(2):169–170.
6. Cunningham F, Gant N, Leveno K, et al. Williams Obstetrics. 21. Mcgraw-Hill; 2001. Ectopic Pregnancy; pp. 899–902.
7. Jianping Z, Fen L, Qiu S. Full-Term Abdominal Pregnancy. A Case Report and Review of the Literature. Gynecol Obstet Invest. 2008; 65(2):139–141. [PubMed]
8. Teng H, Kumar G, Ramli N. A viable secondary intra-abdominal pregnancy resulting from rupture of uterine scar: role of MRI. Br J Radiol. 2007; 80:134–136. [PubMed]
9. Kun K, Wong P, Ho M, Tai C. Abdominal pregnancy presenting as a missed abortion at 16 weeks gestation. Hong Kong Med J. 2000; 6(4):425–427. [PubMed]
10. Stevens CA. Malformations and deformations in abdominal pregnancy. Am J Med Genet. 1993; 47(8):1189–1195. [PubMed].