

Case report

Term alive intra abdominal ectopic pregnancy

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Abstract

A case of term alive intra abdominal ectopic pregnancy. This case is a rarity that a few Gynaecologists encounter during their professional carrier. Initially it was diagnosed as a case of hyperemesis gravidarum and was treated conservatively. Confirm diagnosis was done during laparotomy, a female baby was delivered and the patient recovered uneventfully.

Keywords: ectopic pregnancy; ultrasound; laparotomy; histopathology.

Introduction

An ectopic pregnancy is defined as the implantation of a fertilized ovum outside the uterine cavity. Abdominal pregnancies are very rare case, with the first documented report by Arab surgeon.¹ Incidence figures of ectopic pregnancy vary from 0.3% to 1.4% of all pregnancies^{2,3}. Abdominal pregnancy account for 0.6% to 4% of all ectopic pregnancies and 1 in 3372 to 1 in 21,439 live birth^{4,5,6}. Of these, most are secondary; that is they result from the re-implantation of a ruptured tubal or ampullary pregnancy⁷. A small proportion is primary, with normal Fallopian tubes and adnexa and no evidence of recent or remote injury⁸. Abdominal pregnancy may be life threatening. The diagnosis of abdominal pregnancy is also problem because it can frequently mimic other abdominal and pelvic pathology, including pelvic inflammatory disease (PID). Due to delayed in diagnosis and difficulties in the management of abdominal pregnancy, the risk of morbidity and mortality rate are significantly higher than uncomplicated ectopic pregnancies. Maternal mortality rates range from 0 to over 50% cases, some fetuses live to term with overall fetal mortality rates reported to range from 40-95%^{9,10}.

Case report

A 30 year old lady, para-0 abortion 3 at first trimester, 4th gravida with a history of 6 months amenorrhea presented with pain in the abdomen associated with vomiting and loose motion. She also gave history of induction of ovulation. On examination her pulse rate was 100 beats /min,

BP was 90/60 mm of Hg, abdomen was tender. Fundal height of the uterus was not appreciable, but fetal limbs were palpable more easily than usual. Investigation reports revealed she was haemodynamically stable. The initial three antenatal ultrasonography examinations were done earlier and was reported a single viable fetus with gestational age of 12 weeks, 14 weeks and 23 weeks respectively. The ultrasonography was repeated on admission that revealed partial mole with 25 weeks single live pregnancy with breech presentation. Serum - hCG level was 440mIU/ml, x-ray chest P/A view was reported normal finding. She was treated conservatively till term of pregnancy in the hospital. When her gestational age was 35 weeks, untrasonography was also done and ultrasonologist reported about 35 weeks of live pregnancy with evidence of partial mole. At 37 weeks of gestation laparotomy was done.



Fetal abdomen-surrounded by bowel loops

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Fetus lying in the abdomen

During laparotomy placenta was present in the anterior abdominal wall. After partial removal of placenta a female baby was delivered. Placenta was densely adherent with omentum and intestine, uterus was about 16 weeks of size, upper part of the uterus was lacerated.



Baby was managed by paediatrician



Baby was delivered out

Severe bleeding occurred from torn end of placenta and lacerated portion of the uterus. Uterus was repaired and remaining part of placenta was removed from omentum and intestine. All bleeding points were checked by haemostasis, drain tube was given in pouch of Douglas, abdomen was closed in layers. Blood transfusion was needed during operation.

The newborn was thoroughly checked by the neonatologist and found to be low birth weight (2 kg) with no congenital anomalies. The baby was shifted to paediatric ward. Placental and endometrial tissue were sent for histopathology. Her post operative period was uneventful. Patient was discharged on the 9th day after surgery. Her histopathology report was normal.

Discussion: The most important etiological factors of an ectopic pregnancy are PID, pelvic or abdominal surgery, use of IUD, IVE-ET, induction of ovulation. In my case one of the factors such as induction of ovulation was reported. Viable advanced abdominal pregnancies are very rare. It is assumed that the growth of the peritoneal implanted gestational sac produces symptom as like acute abdomen which is treated conservatively and for this reason, the diagnosis of abdominal pregnancy is often missed even with routine ultrasonography examination, every clinician should have a high index of suspicion for this condition. In a patient with amenorrhoea signs symptoms such as abdominal pain, gastrointestinal disturbances, painful fetal movements, abnormal presentations, uneffaced cervix, vaginal bleeding should arouse suspicion of ectopic pregnancy especially abdominal. For accurate preoperative diagnosis, CT scan and MRI have been used successfully. A lateral x-ray showing fetal parts overlying maternal spine is also helpful. Optimal management requires careful evaluation and planning. Generally speaking for previable abdominal pregnancies with prior to 28 weeks of gestation, immediate operative intervention is indicated but for viable pregnancies presenting after 28 weeks of gestation a more conservative approach is advocated provided the patient can be under strict observation preferably in a hospital. Abdominal pregnancies potentially life threaten with maternal mortality 7.7 times higher than that associated with intrauterine pregnancy. The perinatal mortality rate is also very high due to premature fetal growth retardation and haemorrhage.

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