ADVANCED ABDOMINAL PREGNANCY: A CASE REPORT

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Summary

Advanced abdominal pregnancy is a rare entity demanding high suspicion for diagnosis and challenging management. Maternal outcome is adequate preoperative preparation and skilled surgical management. A case of full term abdominal pregnancy with fetal death has been reported here. The patient presented seven days after her expected date of delivery with slight blood stained vaginal discharge and pain. As her previous pregnancy was terminated by Caesarian section, she was decided for repeat Caesarian section. On laparotomy, a full term dead fetus was removed from an ectopic sac in between abdominal wall and uterus. Uterus was found just bulky with previous scar rupture. After complate removal of gestational sac and placenta and uterine scar repair, abdomen was closed in layers. The patient recovered uneventfully in due time.

Introduction

Abdominal pregnancy is a rare variety of ectopic pregnancy that is implanted on structures in the abdomen other than the uterus, fallopian tubes, ovaries, ligaments[1]. It constitute about 2% of ectopic pregnancies and approximately 0.01% of all pregnancies [2]. It is more commonly seen in patients of low socio-economic status and in developing countries, in those with a history of infertility or pelvic infection[3].

Advanced abdominal pregnancy may be primary in which a fertilized ovum implants itself initially on some abdominal organ. Here tubes and ovaries are normal with no evidence of recent or past pregnancy, no evidence of utero-placental fistula [4].

Most of the abdominal pregnancies are secondary where pregnancy is first implanted in the tube, ovary or uterus and after tubal abortion or uterine scar rupture, it subsequently implants on a nearby peritoneal surface [4].

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Diagnosis of abdominal pregnancy is not so easy. Diagnostic error reported is 50%-90% [5]. Indirect clues for diagnosis [6] are-

- inability to stimulate uterine contraction with oxytocin
- abnormal fetal lie
- oligohydromnios or intra peritoneal maternal fluid.
- impossibility to delineate uterus.

Ultrasound scan should reveal fetal body located outside the uterus as is the ectopic placenta and close approximation of fetal parts with maternal abdominal wall. Radiography should reveal overlapping of maternal spine by fetal small parts in the lateral film and maternal intestine shadows intermingling with fetal parts in the antero-posterior view [3]. Now a days CT scan and MRI have been successfully used to complement sonography in making an accurate pre operative diagnosis[7].

The risk of dying from abdominal pregnancy is 7.7 times greater than from a tubal pregnancy and 90 times higher than an intra uterine pregnancy [3]. The maternal mortality rate is estimated to be 0.5-18% and the perinatal mortality rate is 40-95%[3]. Morbidity is also high resulting in bleeding, infection, toxaemia, DIC, anaemia, pulmonary embolism, fistula formation etc [1].

Treatment of abdominal pregnancy is surgical. The timing of the intervention depends on clinical signs and patient's symptoms. In advanced abdominal pregnancies accompanied by normal fetal development diagnosed in late second trimester, termination of pregnancy may be delayed for a few weeks until the foetus reaches viability. At surgery the gestational sac is opened carefully avoiding disruption of the placenta. The foetus is removed, the cord cut short and the placenta is left in situ if complete removal is not possible. The residual placental tissue will absorb slowly over a period of many months, sometimes a few years [8].

Now we will present and discuss about a case of advanced abdominal pregnancy diagnosed on lapartomy.

Case report

Mrs. Nargis Akther, a 25 year old house wife of

poor socio-economic status hailing from Rangunia was admitted in labour ward of CMCH on 1st July,2009 at 10:30PM . She was second graved and her first baby was delivered by caesarian section 4 year back due to ante partum eclampsia. This time her ante natal period was uneventful except occasional abdominal discomfort. She had irregular ante natal check up with no ducumented evidence and she claimed to feel fetal movements till admission in CMCH 7 days after her expected date of delivery. (LMP-18.09.2008, EDD-25.06.2009)

On examination she was well looking, mildly anemic, non-icteric with pulse -100/min, BP-120/80mmHg, temp-normal, oedema-absent. Abdomen was distended upto xiphoid process, but no definite contour of uterus was found. Foetal parts were not easily and palpable, fetal movement and fetal heart sound not detected. P/V exam revealed, cervix- long tubular, os closed, posteriorly placed, presenting part not felt, but slight blood stained discharge was present. She was diagnosed as a case of 2nd gravid with FTP with 7 days overdue with P/H/O LSCS with labour pain possibilitis of scar rupture was in mind after opening the abdomen,

Fig 1: Ectopic sac infront and uterus behind

Fig 2 : Full term fetus removed from abdominal cavity

Fig 3 : Uterine scar repair. Here uterus is bulky, tubes and ovary almost normal

a dead fetus was delivered from an ectopic sac attached in between anterior wall of abdomen and uterus. Omentum and gut wall was also adhered to ectopic sac. With cautiom, ectopic sac was separated from adjacent structures and removed in piecemeal along with dead placental tissue. Uterus was found just beneath the sac, it was bulky with rupture of anterior wall along with previous Caesarian scar through which the edges of ectopic sac communicated. Both ovaries and fallopian tubes were healthy. Uterine scar was repaired and after checking other abdominal structures and ensuring haemostasis, abdomen was closed in layers keeping a drain in situ. Patient was haemodynamically stable and her post operative recovery was also smooth. She was discharged on 8th post operative day.

Discussion

Abdominal pregnancy is a rarity that only a few gynaecologist will encounter during their professional career. Most cases of abdominal pregnancy are secondary in that the pregnancy is first implanted in the tube, ovary or uterus. From uterus, it escapes by way of rupture of a scar. In presented case the uterus was just bulky (6-8 wk size) and the gestational sac escaped through scar rupture at early stage (6-8 wk) and developed there after upto term so it was case of secondary abdominal pregnancy. Abdominal pregnancy causes comparatively few symptoms and because of its rarity, the condition may not be suspected clinically. So diagnosis is often delayed and not frequently made until laparotomy. Our case is also diagnosed at laparatomy. Our patient was fortunate that complete removal of placenta and gestational sac was possible with minimal blood loss though laparatomy was done at mid night without any pre operative speculation and preparation. She did not suffer any

morbidity like profuse hemorrhage sepsis, etc. which could endanger her life. Though several cases of full term abdominal pregnancy were reported worldwide; only two of them were alive fetus[9]. If our patient presents earlier (before expected date of delivery), the fetus might be brought out alive. However risk of haemorrhage was less in our patient as fetus and placenta were already dead.

Conclusion

Abdominal pregnancy is a rare entity with high diagnostic error of 50-90%. High index of suspicion is necessary for diagnosis. Obstetricians should be alert of such conditions and should take suggestions and help from experienced one in managing such cases.

Disclosure

All the authors declared no competing interestes.

References

1. Laila A, Shiuly C, Mazhar SI. Diagnostic dilemma in abdominal pregnancy A case report. Journal B.C.P.S. 2009; 27: 177-179
2. Mosby's Medical dictionary.8th edition.US: Elsevier 2009. Abdominal pregnancy
3. Kassam M. Abdominal pain in pregnancy. In David KJ, Philips JS, Carl PW, Bernard G, editors. High risk pregnancy: Management option London: WB Saunders 2007; 2: 996-997
4. Ectopic pregnancy. In Protap K, Narendra M.,editors.Jeffcoate's Principles of Gynaecology. New Delhi: JP Brothers Med Pub. 2008; 7: 157-159
5. Rahman MS, Al suleiman SA, Rahman J, Al sebai MH, Advanced abdominal pregnancy-observation in 10 cases. Obstet. Gyneacol. 1982; 59: 336-372
6. Amanda Cotter MD, Luis Isquierdo MD, Fernendo Heredia MD, Abdominal pregnancy. Cotter www. The fetus net 2002; 10-22
7. Allibone GW, Fagan CJ, Porter SC. The sonographic features of intra abdominal pregnancy. J Clin. Ultrasound 1981; 9: 383-387
8. Davor Jurkovic.Ectopic pregnancy.In KeithEdmonds, editor. Dewhurst's textbook of Obstetricsand Gynaecology. Oxford, UK:Blackwell. 2007; 7: 115
9. Full term intra abdominal ectopic pregnancy, surgical treatment of five cases. Irish Journal of Medical science (1926-1967). Publisher Springerlink 2008