

## Term Viable Abdominal Pregnancy- A Case Report

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### Abstract

A lady of 24 years was presented with the complains of 40 weeks pregnancy and abdominal pain for 3 days. Her abdominal examination revealed that abdomen was tense, tender, uterine contour could not be ascertained. A lining foetus of transverse lie was felt in the upper part of abdomen. Liquor was seems to be insufficient. Her USG findings was term pregnancy, oligohydramnions, transvers lie with central placenta previa. Her laperatomy finding was intact shiny amniotic sac was present at the upper part of abdomen, uterus was 12 weeks size and was in normal position that is within the pelvic cavity. Lie of the foetus was transverse, placenta was found to be implanted on the fundus of uterus. Baby was delivered by breech extraction. Subtotal hysterectomy was done due to profuse uncontrolled bleeding from placental implantation site. Her post operative period was uneventful and recovery was good. She was discharged on 8th post operative day.

**Key words:** Abdominal pregnancy, Tern viable.

### Introduction

An extrauterine pregnancy is one in which the conceptus develops in the abdominal cavity after being extruded from the fimbriated end of the fallopian tube or through a defect in the tube or uterus<sup>1,2,3</sup>. The placenta may implant on the abdominal or visceral peritoneum<sup>4,5</sup>. Abdominal pregnancy may be suspected when the abdomen has enlarged but the uterus has remained small for the length of gestation<sup>6,7,8</sup>. Abdominal pregnancies constitute approximately 2% of ectopic pregnancies and approximately 0.01% of all pregnancies<sup>9,10</sup>. One in 8000 term births is an abdominal pregnancy<sup>11,12</sup>. The condition results in perinatal death of the foetus in most cases<sup>13</sup>. Maternal death is approximately 6%<sup>14,15</sup>. Because of its rarity the condition may not be suspected and diagnosis is often delayed<sup>16,17</sup>. Ultrasound or X-Ray visualization showing gas in the maternal bowel below the fetus is diagnostic of the condition<sup>18</sup>. Surgical removal of the placenta, sac and embryo or fetus is

necessary if attached to the fallopian tube, ovary broad ligament or uterus<sup>17,18</sup>. The procedure is often complicated by massive bleeding because the placenta tends to adhere firmly to the peritoneum and the bowel, complete removal is seldom possible<sup>19</sup>. Allowing it to be absorbed presents fewer problems<sup>19</sup>. Post operative sequelae may include retained placental tissue, infection, continued bleeding and sterility<sup>19,20</sup>.

### Case Report

A lady of 24 Yrs. hailing from daudkandi thana of Comilla district was admitted in Institute of child and mother health, Matuail, Dhaka on 16<sup>th</sup> December 2009 at labour emergency with complains of pregnancy for 40 weeks with lower abdominal pain for 3 days. She was third gravid with history of two vaginal delivery. Her age of the last child was 6 yrs. On examination she was anaemic and normotensive, ill looking. Her abdominal examination revealed that, abdomen was tense, tender. Contour of uterus could not be elicited. A foetus of transverse lie was felt in the upper part of abdomen. Liquour was seems to be less than adequate. Foetal heart sound was audible.

Investigations revealed hemoglobin was 7.3 g/dl, blood group 'O' Positive. She was non diabetic. According to USG she was diagnosed as a case of term pregnancy, oligohydramnios, transverse lie with central placenta previa. Patient underwent laparotomy on the same day of admission. under spinal anesthesia, abdomen was opened by pfanenstiel incision. After opening of the abdomen it was found that an intact shiny amniotic sac was present at the upper part of abdomen uterus was 12 weeks size and was in normal position that is within the pelvic cavity. Lie of the foetus was transverse. After rupture of the amniotic sac baby was delivered by breech extraction. placenta was found to be implanted on the fundus of the uterus. During removal of placenta, profuse bleeding occur from implantation site which was uncontrolled. Subtotal hysterectomy was done. Thereafter bleeding was controlled. Patient received six bag of whole blood. Baby was healthy female weighing 1.8 kg and apgar score was 7/10. Her post operative period was uneventful and recovery was good. She was discharged on 8th post operative day with good health and a healthy baby accompany her.

### Discussion

An Undiagnosed abdominal pregnancy, which progresses is to term, may be asymptomatic. Indirect clues for this diagnosis are :

- Abnormal foetal lie.
- Oligohydramnios or intra peritoneal maternal fluid.

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- Impossibility to delineate uterus.
- The inability to stimulate uterine contractions with oxytocin.

To diagnose an abdominal pregnancy on ultrasound one should try to delineate the uterus as a separate structure from the fetus and placenta. In some cases MRI can be useful to demonstrate the relationship between the fetus, cervix and myometrium.

The diagnosis is frequently not made until laparotomy. Regardless of gestational age, removal of the placenta can result in haemorrhage. Angiographic arterial embolization may be considered as an option for such cases. The placental blood supply can be ligated and the pelvic organs upon which implantation occurred removed. If placenta is not manipulated, the umbilical cord can be ligated close to the placenta and left in situ. Placental involution can be followed by serial ultrasounds and serum  $\beta$ -HCG titers. Some have advocated the use of methotrexate with varying degrees of success. Risks associated with leaving the placenta in sites include bowel obstruction, fistula formation and sepsis as the tissue degenerates.

Abdominal pregnancy is a serious and potentially life threatening condition. The maternal mortality rate is estimated between 0.5 and 18%. The perinatal mortality rate ranges between 40-95%. The deleterious effect of abdominal pregnancy on the mother and fetus is partly related to the morbidity of the surgical intervention.

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