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Case Report

Secondary Abdominal Pregnancy at term: a case report

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Abstract:

Abdominal pregnancy is a rare form of ectopic pregnancy and a serious form of extrauterine pregnancy. Abdominal pregnancy account for almost 1% of ectopic pregnancies. Rarely,it may reach at advanced gestation and a viable fetal outcome is a rare event. Sometimes, the diagnosis is suspected only when repeated attempts of induction of abortion or labor are unsuccessful. Really it is difficult to diagnose and manage. Here we are reporting a case of secondary abdominal pregnancy in a 27 years old primi gravida at 39+ weeks of gestation. It was observed from her ultrasonography that a single live pregnancy with breech presentation with almost absent liquor with IUGR baby then decision was made for lower uterine cesarean section under sub-arachnoid block. But it was turned into laparotomy and diagnosed as a secondary abdominal pregnancy. A healthy female baby was delivered. The placenta was attached with the omentum and large bowel loop. After tying and cutting the cord flushed with it's placental attachment, placenta was kept in situ. Abdomen was closed in layers. The diagnosis of abdominal pregnancy was made peroperatively with successful management and delivery of a healthy female baby.

Key words: Abdominal pregnancy, Term pregnancy .

Introduction:

Abdominal pregnancy is a very uncommon form of ectopic pregnancy and a life threatening form of extrauterine pregnancy. Frequency of abdominal pregnancy is about less than 1%. A rare case of abdominal pregnancy with delivery a healthy baby presented here.

Case history:

A 27 years old primi gravid women hailing from Rajbari, Bangladesh got herself admitted in Bangabandhu Sheikh Mujib Medical College Hospital, Faridpur at her 39 weeks of gestation with the complaints of less fetal movement on 8 February 2022. She was not under regular antenatal check-up. Her last menstrual priod was 5 May 2021. Accordingly her expected date of delivery was 12 February 2022.

At her 11 weeks of pregnancy she noticed slight per-vaginal bleeding, so she went for antenatal check-up and ultrasonography diagnosed 11 weeks of missed abortion and undergone D&C from an untrained person. But she remained amenorrheic and her signs and symptoms of pregnancy persistened. So again 1.5 months later she had an ultrasonography and diagnosed 18 weeks of single alive intrauterine pregnancy with breech presentation with scanty liquor. Her pregnancy was continued without any complications. During her antenatal period she had ultrasonography for several times and every report suggested single live intrauterine fetus with scanty liquor with breech presentation with IUGR and cesarean section was planned. She was hemodynamically stable. Her haemoglobin level was 10g/dl. She didn't complaints any abdominal pain, vomiting or constipation.

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A pfannenstiel incision was given. During opening of abdomen it was quite difficult to open the peritoneum. Dissection was carried out. After opening the peritoneal cavity we found a fibrous sac with dilated blood vessels on its surface and urinary bladder densely adherent anteriorly. A healthy female 2.3kg baby was delivered by breech extraction through transverse incision on the fibrous sac. Placenta could not be separated and outline of uterus could not be delineated well. After exploration uterus was found below and behind the peritoneal mass. Both ovary and fallopian tube were healthy. The placenta was attached to the omentum and gut. Bleeding was profound and several deep bites were given on placenta and it was kept in situ. The baby had no congenital anomalies. Both the mother and the baby were kept in the hospital up to 10th post operative day. During this time she complained no sign of infection or abnormal bleeding. Patient was kept in follow up by serial ßhCG and ultrasonography and coagulation profile. We did not give Methothrexate. Patient is doing well without any complaints.

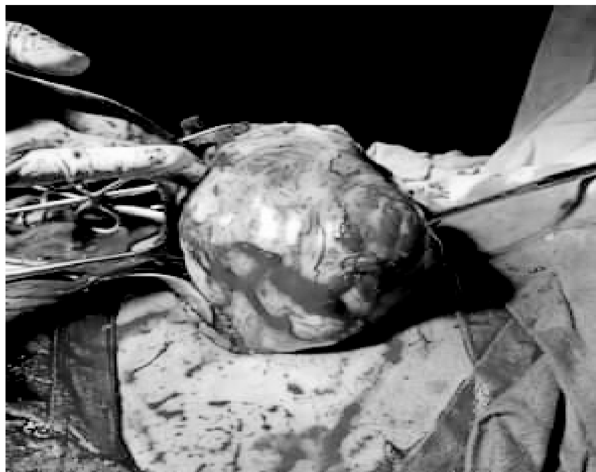

Fig-1: Fibrous sac.

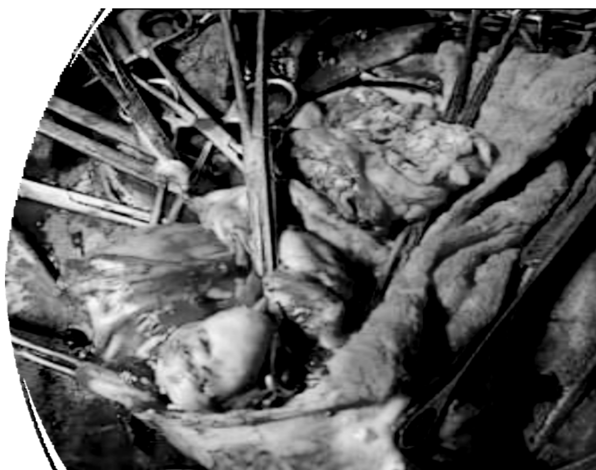

Fig-2: Placenta attachment site.

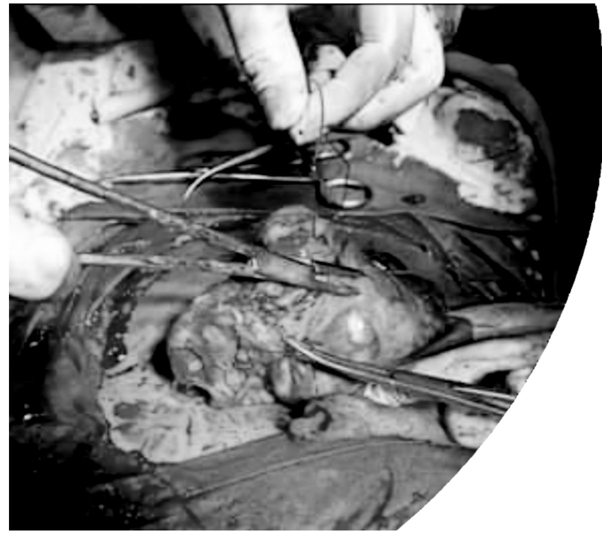

Fig-3: Control haemostasis and tying placenta.

Discussion:

Advanced secondary abdominal pregnancy can have catastrophic consequence for the foetus and the mother. Abdominal pregnancy is difficult to diagnosis and manage by physicians working in remote area with limited resources[1]. It is important to keep attention for the clinicians and ultrasonographers to bear in mind the possibility of abdominal pregnancies especially in the condition of foetal malpresentation, hisatory of abdominal pain, malformations or oligohydramnios[2]. Extra uterine pregnancies should be considered in all patients until an intrauterine location can be confirmed by ultra sound imaging, otherwise it may create potentially life-threatening condition[3].

If diagnosis of abdominal pregnancy before 20 weeks can be made, immediate termination should be offered. Advanced abdominal pregnancies can be monitored under close surveillance and delivered at 34 weeks of gestation after fetal lung maturation achieved[4]. The co-existence of spontaneous full-term intrauterine with advanced abdominal pregnancy is a rarest forms of heterotopic pregnancy[5].

According to studdofords' criteria,the diagnosis of primary abdominal pregnancy is based on the following anatomical conditions:

* Normal looking tubes and ovaries.
* No connection or fistula between the uterus and abdominal cavity.
* Thirdly,pregnancy should be related only to the peritoneal cavity without signs that it was a tubal prenancy at any time[6].

Conclusion:

Term abdominal pregnancy is a rare form of ectopic pregnancy and life threatening complications like bleeding from the detached placental site may happened. Abdominal pregnancy is challenging for the diagnosis, timely intervention and surgical procedure. Diagnosis can be missed by inexperienced radiologist. Early and accurate diagnosis play important role in reducing maternal mortality and morbidity.

Consent:

Informed written concent was obtained from the patient for publication of this case report.

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