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Case Report

Advanced Undiagnosed Abdominal Pregnancy with Good Maternal & Fetal Outcome - A Case Report

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Abstract

An ectopic pregnancy is one in which the embryo implants outside the uterus. An abdominal pregnancy is a rare variety of ectopic pregnancy, Abdominal pregnancy may be primary or secondary. In primary abdominal pregnancy the initial & final implantation site is out side the uterus. But in secondary abdominal pregnancy the embryo starts out implanted in the uterus, but due to unusual circumstances such as uterine rupture the placenta grows out side the uterus. However, in most cases of abdominal pregnancy are secondary. So that, in areas where ectopic pregnancy are common the incidence of abdominal pregnancies is increased also. An abdominal pregnancy causes few symptoms. None of them are individually diagnostic, so the diagnosis depends on the sum of many clues, none of which is enough by itself. Patient may display the normal signs of pregnancy or have non-specific symptoms such as abdominal pain, vaginal bleeding and /or gastro-intestinal symptoms but frequently the diagnosis is missed. We are reporting a 35 year old lady with abdominal pregnancy with good maternal and fetal outcome.

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Introduction

About 1% of ectopic pregnancy in the United States is abdominal or about 10 out of every 100000 pregnancies[1]. An ectopic pregnancy is one in which the embryo implants outside the uterus. An abdominal pregnancy is a rare variety of ectopic pregnancy. Abdominal pregnancy may be primary or secondary. In primary abdominal pregnancy the initial & final implantation site is out side the uterus. But in secondary abdominal pregnancy the embryo starts out implanted in the uterus, but due to unusual circumstances such as uterine rupture the placenta grows out side the uterus. However, in most cases of abdominal pregnancy are secondary. So that, in areas where ectopic pregnancy are common the incidence of abdominal pregnancies is increased also. An abdominal pregnancy causes few symptoms. None of them are individually diagnostic, so the diagnosis depends on the sum of many clues, none of which is enough by itself. Patient may display the normal signs of pregnancy or have non-specific symptoms such as abdominal pain, vaginal bleeding and /or gastro-intestinal symptoms but frequently the diagnosis is missed

Case-report

Mrs selina, 35yrs old P_{0+3}, 4^{th} gravida house wife of middle class family, hailing from Sujanagar,

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Pabna was abmitted in Rajshahi medical College Hospital on 4th October 2010 with the complaints of amenorrhoea for 24 weeks & severe lower abdominal pain & vomiting for 2days. Patient state that she was a regularly menstruating women with average flow & duration. Her L.M.P was on 09.04.10 accordingly E.D.D will be on 16.01.11. Her pregnancy was dated by early USG & finding was 7 weeks intra-uterine pregnancy. At 11 weeks of pregnancy she developed severe lower abdominal pain, vomiting, abdominal distension & passage of P/V brownish discharge and for this problem she went to Sujanagar health complex & treated conservatively. She also gave H/O syncopal attack for 3-4 times at home with lower abdominal pain up to 24 weeks of pregnancy & for this problem she admitted in Pabna Sadar hospital 4-5 times & treated conservatively & 6 units of fresh blood was transfused for severe anaemia in that hospital.

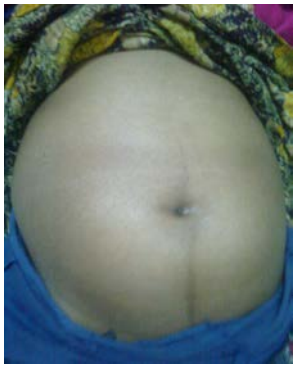
At her 23 weeks of pregnancy, USG was done at Pabna Sadar hospital & diagnosed a case of single live intra-uterine pregnancy with central placenta praevia with oligohydramnios with partial mole.
On 3rd October, she again developed severe lower abdominal pain with vomiting & referred to RMCH for better management as her condition not improved in spite of conservative treatment.

As the patient had past bad obstetrical history & many complications then decision was taken to admit the patient in hospital till term. During admission regular follow up & investigation was done & treated by bed rest, improved diet, vitamin, calcium, iron & folic acid supplementation. Tocolytic drugs & low dose aspirin. At 32 weeks, tocolytic drugs and aspirin were stopped & inj steroid was given for lung maturation. But on 14th December at her 36 weeks of pregnancy, She again developed severe lower abdominal pain & decision was taken for emergency caesarean section. After opening of peritoneum, it was found that placenta & gestational sac like structure was spread all over the abdomen, gut & omentum. No uterus & foetal parts were felt.

Multiple dilated tortuous, engorged blood vessels were present all over the structure of abdomen & very gently placenta like structure separated & fetal parts are felt. & foetus delivered.

After delivery of foetus, uterus felt in its normal position and it was about 10 weeks pregnancy size but placenta attached with outer surface of posterior wall of uterus and here also a rent present which was repaired properly.

There was massive bleeding during this procedure. It was very difficult to achieve haemostasis & placental separation. After proper haemostasis & toileting abdomen is closed layer by layer & placenta was sent for histopathopogical examination. After delivery, baby was managed by neonatologist. No foetal anomaly was detected, sex-female, weight-2kg, A/S-6/10. Post operative period was uneventful & discharged on 8th post-operativeday with a healthy baby.



Term pregnancy size abdomen having Abdominal pregnancy

Healthy baby of abdominal pregnancy after loparotomy

Discussion

A primary abdominal pregnancy is one in which fertilized ovum implants directly in the abdominal cavity and its organs, save for the tube & ovaries. Such pregnancy are very rare. Only 24 cases had been reported by 2007. However, most cases of abdominal pregnancy are secondary in that the

pregnancy is first implanted in the tube, ovary or uterus & then it escapes by way of rupture of a scar. The criteria for diagnosis of primary abdominal pregnancy are: normal tubes & ovaries with no evidence of recent or past pregnancy, no evidence of utero-placental fistula and the pregnancy is related solely to the peritoneal surface without sign that there was a tubal pregnancy first.

The diagnosis of abdominal pregnancy is a real problem. Diagnosis depends on recognizing. (a) that she is pregnant (b) that her pregnancy is not in her uterus. Her history seldom helpful but.

(i) She may had episodes of pain in early pregnancy

(ii) She may have a history of previous ectopic pregnancy

(iii) If she is an experienced multipara she may say that her pregnancy feels different.

The fetus implant it self any where but placenta is so large, it is always attached to gut, omentum, POD, brood ligament & on ovary. Babies of abdominal pregnancy often have birth defects due to compression in the absence of amniotic fluid buffer. The rate of malformation & deformities is estimated to be about 21%, typical deformities are facial & cranial asymmetries & joint abnormalities & the most common malformation are limb defects & CNS malformation[2].

Once the baby has been delivered placental management become an issue. In normal deliveries the contraction of uterus provides a powerful mechanism to control blood loss, however in an abdominal pregnancy the placenta is located over tissue that cannot contract & attempts of its removal may leads to significant blood loss. So, all procedures during operation should be done very gently. Generally unless the placenta can be easily tied of or removed it may be preferable to leave it in place and allow for natural regression[3/4]. This process may take about four months & can be monitored by checking ßHCG level.

Use of methotrexate to accelerate placental regression is controversial as large amount of necrotic tissue is a potential site for infection[3]. Placental vessels have also been blocked by angiographic embolization[5].

Conclusion

Abdominal pregnancy is a dangerous condition. The placental attachment is so insecure & local decidual reaction so week that embryo / fetus can die at any stage or proceed to term and any time severe retroplacental & intra abdominal haemorrhage resulting in medical emergency like haemorrhagie shock & can be fatal; other causes of maternal death in patient with an abdominal pregnancy include toxaemia, anemia, pulmonary embolus, coagulopathy & infection.

It is generally recommended to perform laparotomy when the diognosis of an abdominal pregnancy is made. However if pregnancy is past 24 weeks and baby is alive & medical support system are in place, careful watching should be considered to bring the baby to viability (34-36weeks). Woman with an abdominal pregnancy will not go into labour. Delivery in a case of an advanced abdominal pregnancy will have to be via laparotomy. The survival of the baby is reduced and high perinatal mortality rates between 40-95% have been reported[6], than ectopic pregnancy in general but on occasion can lead to a delivery of a viable infant.

Here in our case due to vigilance care & timely inference we save life of mother & baby.

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