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Case Report

A case report on a rare case of abdominal ectopic pregnancy

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ABSTRACT

Abdominal pregnancy is a rare and potentially life-threatening form of ectopic pregnancy, accounting for approximately 1-2% of all ectopic gestations and associated with high maternal morbidity and mortality. Due to its variable presentation and diagnostic challenges, it is often misdiagnosed as an intrauterine pregnancy, leading to delayed management. We report a case of a 35-year-old sterilised woman, gravida 5 para 3, who presented at 26 weeks of gestation with three months of amenorrhea followed by irregular vaginal bleeding for 20 days. Initial evaluation suggested an intrauterine pregnancy with fetal demise; however, failure of induction and further ultrasonographic evaluation revealed an abdominal ectopic pregnancy with the fetal head located in the pouch of Douglas. The patient underwent exploratory laparotomy with en-masse removal of the fetus and placenta. Intraoperatively, the placenta was found adherent to the sigmoid mesentery without invasion of major pelvic organs. Postoperative recovery was largely uneventful, and the patient was discharged in stable condition. This case highlights the importance of maintaining a high index of suspicion for abdominal pregnancy, especially in patients with atypical clinical findings and poor response to induction. Early diagnosis, appropriate imaging, meticulous surgical planning, and a multidisciplinary team approach are crucial to reduce maternal morbidity and mortality associated with this rare condition.

Keywords: Abdominal ectopic pregnancy, Ultrasound, Multidisciplinary, Laparotomy

INTRODUCTION

Abdominal pregnancy is a rare form of ectopic pregnancy which accounts 1-2% of all pregnancies with high morbidity and mortality. There are only a limited number of case reports of abdominal ectopic pregnancies. We present a case of a 35-year-old sterilized woman who presented at 26 weeks gestation with amenorrhea for 3 months and followed by irregular bleeding per vagina for 20 days. A sonogram demonstrated an abdominal ectopic pregnancy. The patient underwent exploratory laparotomy with removal of the ectopic pregnancy. Our case presents an opportunity to discuss a rare form of ectopic pregnancy and the importance of proper diagnosis and treatment to reduce morbidity and mortality. An abdominal ectopic pregnancy is a pregnancy that occurs outside the uterus and

in the abdominal cavity. Common forms of placental implantation in abdominal pregnancies include attachment on reproductive organs with subsequent rupture into the peritoneal cavity, as well as direct attachment to uterine serosa, omentum, bowel, and mesentery.^{1,2} Abdominal ectopic pregnancies increase the risk of fatal intraperitoneal hemorrhage.² Therefore, it is important to diagnose and effectively manage this rare type of pregnancy in order to reduce morbidity and mortality.

CASE REPORT

A 35-year-old gravida 5, para 3, living 3 and 1 miscarriage sterilized woman presented to IMCH Government medical college Calicut at 26 weeks of gestation with amenorrhea for 3 months followed by irregular bleeding per vagina for

20 days. She was initially thought to have an intrauterine pregnancy with fetal demise. She had no history of sexually transmitted disease, pelvic inflammatory disease, or endometriosis.

Her past history had only laparoscopic sterilization surgery. Per abdominal examination revealed a 20-week size uterus but bimanual exam revealed a firm cervix with bulky uterus and a mass in the posterior fornix. Fetal heart sound not localized. In spite of multiple induction she was not getting contraction and per vaginal examination examination was same. This made us suspicious of abdominal pregnancy and ultrasound taken showed fetal head in pouch of Douglas (abdominal pregnancy).

She was counselled on the need for surgical removal of the ectopic pregnancy to save her life. Surgery and urology services were all consulted. Enough blood was arranged and planned for laparotomy.

On abdominal entry, pregnancy was in Pouch of Douglas and the sigmoid mesentery was adhered and draped across the placenta. It did not invade uterus, pelvic vasculature or the colon. Fetus and placenta were removed as enmass. The fetus was identified inferior to the placenta on the patient's left. The left tube and ovary was found to be adhered in the mesentery.

The initial intention was to leave the placenta to reduce the risk of hemorrhage, but they were already separated by its own. Left fibroidectomy and right partial salpingectomy done. An intraperitoneal drain was kept. Postoperatively antibiotics (Piptaz) and thromboprophylaxis given, vitals stable and adequate urine output. Drain collected 200 ml for 48 hours. Had multiple fever spikes blood and urine culture was sterile otherwise postoperative period was uneventful. Discharged on postoperative day 12.



Figure 1: Fetal head in POD.



Figure 2: Laparotomy

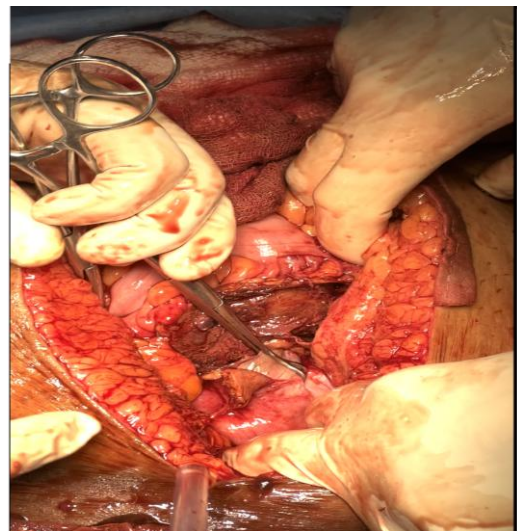


Figure 3: Fetus in POD.

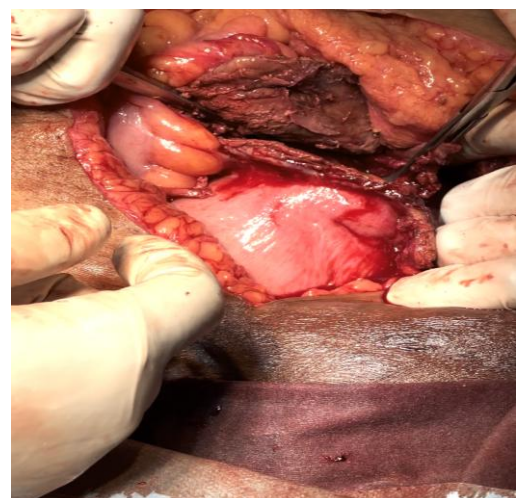


Figure 4: Placenta in mesentery.



Figure 5: Fetus with placenta.

DISCUSSION

Ectopic pregnancies comprise 1% to 2% of all pregnancies, with most occurring in the fallopian tube.³ In rare cases ectopic pregnancies can be found in the abdominal cavity; these pregnancies consist of about 1% of all ectopic pregnancies.³⁻⁷ Due to the potential complication of hemorrhage from the placental implantation site, abdominal ectopic pregnancies have a high morbidity and mortality.²⁻⁸ As a consequence, proper diagnosis and treatment are essential.

Risk factors for abdominal pregnancy include previous ectopic pregnancy, tubal surgeries/rupture, endometriosis, and pelvic inflammatory disease.¹ While abdominal pregnancy presentation is variable, findings such as severe abdominal pain and painful fetal movement should raise suspicion for abdominal pregnancy.⁶ Due to the variability of symptoms, abdominal pregnancies can be misdiagnosed.⁵ In our case, the pregnancy was initially thought to be intrauterine; however, a sonogram showed the presence of an extrauterine pregnancy. Ultrasound findings showing an empty uterus, with a gestational sac or mass outside of the uterus, fallopian tubes, and ovaries confirming the diagnosis of abdominal pregnancy.¹⁻⁵ If the diagnosis of abdominal pregnancy is inconclusive with ultrasound findings, magnetic resonance imaging can be used.⁵ Further, beta-human chorionic gonadotropin levels early in the pregnancy >1500 mIU/mL without an intrauterine gestational sac should warrant concern for abdominal or other ectopic pregnancies.⁸

Abdominal pregnancy before 24 weeks is generally treated with laparotomy with removal of the ectopic pregnancy with or without placental removal (if low risk of maternal hemorrhage).³⁻⁶ A multidisciplinary surgical team including vascular surgery, trauma surgery, urology, and gynecological oncology may be warranted due to the risk for heavy bleeding, complicated pelvic surgery, and urological involvement. It is important to continue to follow the patient for risk of postoperative complications such as hemorrhage or infection.⁸ There have been rare

instances in which abdominal ectopic pregnancies have been diagnosed later in the pregnancy and carried to term.^{3,4,6,8,9} As abdominal pregnancies are associated with a high risk of maternal and perinatal mortality, it is always important to encourage proper counseling and shared decision making between the patient and provider before deciding upon a treatment plan.^{4,6,7}

CONCLUSION

Through this case report, we wish to emphasize the importance of early diagnosis and difficulties in the management of abdominal pregnancy, the risk of mortality is significantly higher than for uncomplicated ectopic pregnancies. The condition can be primary, if the pregnancy implants directly on to an abdominal site, or it can be secondary after a tubal abortion. Abdominal ectopic pregnancy differs from tubal pregnancies by a normal level of human chorionic gonadotropin and rare vaginal bleeding, which causes a diagnostic delay. In an early pregnancy the treatment is laparoscopic removal, but in second and third trimester pregnancies, laparotomy is preferred, if possible preceded by MRI for mapping of vascular involvement and location of placenta. A multidisciplinary team approach with proper planning, coordination, availability of blood and blood products, and laboratory support are critical for the safe management of abdominal pregnancy and help in optimum recovery and prevent morbidity and mortality.

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