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Case Report

A rare case of secondary live advanced abdominal pregnancy

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ABSTRACT

A 25-year-old gravida 2 para one with a history of 8 months lactational amenorrhoea presented to labour room with pain in abdomen since, 20 days in shock. Fundal height of uterus corresponded to 34 weeks size with unstable lie and uterus was relaxed. Fetal parts were palpable more easily than usual. Fetal heart sound was good. Pelvic examination revealed uneffaced and undilated cervix. Antenatal ultrasonography showed a single, viable fetus with gestational age of 33 weeks 6 days with oblique lie with head in right lower quadrant. Placenta was located in lower uterine segment covering internal os with AFI – nil with normal fetal cardiac activity and fetal movement. On opening the abdomen there was a boggy mass in the lower pelvic cavity with fetus with intact membrane lying in the abdominal cavity. Baby was delivered by breech extraction Baby weighed 2.2kg with no congenital anomaly. Placenta with membrane was in the left non-communicating horn of uterus with feeding vessels from omentum which were clamped, cut and ligated. The non-communicating horn with placenta was resected and left salpingo oophorectomy was done. Examination of intraabdominal viscera confirmed no injury. There was no torrential haemorrhage intraoperatively and abdomen was closed in layers after achieving proper hemostasis.

Keywords: Abdominal pregnancy, Breech extraction, Feeding vessels, Left non communicating horn of uterus

INTRODUCTION

Abdominal pregnancy, with a diagnosis of one per 10,000 births, is an extremely rare and serious form of extra uterine gestation. Abdominal pregnancy account for almost 1% of ectopic pregnancies. It has a reported incidence of one in 2,200 to one in 10,200 of all pregnancies.¹ The incidence of advanced abdominal pregnancy is approximately 1 in 25000 births. The maternal mortality rate can be as high as 20%.¹ Survival of newborn is also affected with a perinatal mortality of 90% to 95%.

CASE REPORT

A 25-year-old gravida 2 para one with a history of 8 months lactational amenorrhoea presented to labour room

with pain in abdomen since, 20 days on dt. 9.7.15. On examination, she had a heart rate of 115 beats/min., blood pressure was 100/70 mm of Hg, respiratory rate was 18/min and temperature 98.4°F. Examination of her cardiac and respiratory system was unremarkable. On abdominal examination mild, generalized tenderness was present. Fundal height of uterus corresponded to 34 weeks size with unstable lie and uterus was relaxed. Fetal parts were palpable more easily than usual. Fetal heart sound was good. Pelvic examination revealed uneffaced and undilated cervix.

The initial antenatal ultrasonography examination done earlier reported a single, viable fetus with gestational age of 33 weeks 6 days with oblique lie with head in right lower quadrant. Placenta was located in lower uterine segment covering internal os with AFI-nil with normal fetal cardiac activity and fetal movement. No obvious

congenital anomaly was detected. A fibroid of size about 56x63mm was seen lower uterine segment.



Figure 1: Placenta in non-communicating horn.

Exploration laparotomy was done after two doses of Inj. Betnesol on 13.7.15 with indication of placenta praevia with AFI-nil. On opening the abdomen there was a boggy mass in the lower pelvic cavity with fetus with intact membrane lying in the abdominal cavity.



Figure 2: Placenta attached to omentum.

Baby was delivered by breech extraction and handed over to neonatologist for resuscitation. Baby weighed 2.2kg with APGAR score of 2 at birth and 6 after 6 minutes respectively and screened thoroughly by neonatologist and found to be premature with IUGR with no congenital anomaly.



Figure 3: Major part of placenta in non-communicating horn.

Placenta with membrane was in the left non-communicating horn of uterus with feeding vessels from omentum which were clamped, cut and ligated. The non-

communicating horn with placenta was resected and left salpingo oophorectomy was done.



Figure 4: Omentum feeder vessels ligated.

Examination of intraabdominal viscera confirmed no injury. There was no torrential haemorrhage intraoperatively and abdomen was closed in layers after achieving proper hemostasis. Her post-operative period was uneventful. Mother with the healthy baby were discharged on 7th post op day.



Figure 5: Left horn with placenta is cut.



Figure 6: After excision.

DISCUSSION

Abdominal pregnancies are those in which implantation occurs within the peritoneal cavity excluding tubal, ovarian or intra ligamentary sites of implantation. Such pregnancies are potentially life threatening with maternal mortality 7.7 times higher than that associated with intrauterine pregnancy. Viable advanced abdominal

pregnancies are very rare and only few sporadic cases have been reported in the past 10-15 years. It is classified into two types. Primary abdominal pregnancy refers to pregnancy where implantation occurs directly in the abdominal cavity with intact fallopian tubes and ovaries. Secondary abdominal pregnancy usually occurs following ruptured extrauterine tubal pregnancy and gets reimplanted within abdominal cavity. In this report, the patient complains of intermittent suprapubic pain with history of 3 days bleeding P/V in early pregnancy. Ectopic pregnancy occurred in non-communicating horn of uterus by transcoelomic migration and subsequent implantation in non-communicating horn of uterus that had ruptured and secondarily implanted in peritoneal surface followed by growth of fetus in abdominal cavity with feeding vessels from omentum. The diagnosis was missed during antenatal care and ultrasonography finding was mis-interpreted as an intrauterine pregnancy with low lying placenta and the normal uterus was mis-interpreted as fibroid. A recent report of 163 cases of extrauterine abdominal pregnancy demonstrated that the diagnosis of this condition is frequently missed with only about 45% of cases diagnosed during antenatal period.²

Typically, the patients present with persistent abdominal and/or gastrointestinal symptoms, painful fetal movements, abnormal presentation, vaginal bleeding, uneffaced cervix and failed induction. On clinical examination fetal parts are easily felt and lie is usually abnormal.³ Ultrasonography remains the main method for diagnosis which usually shows no uterine wall surrounding the fetus, fetal parts are very close to the abdominal wall, abnormal lie and/or no amniotic fluid between placenta and fetus.³ For accurate preoperative diagnosis CT scan, MRI have been used successfully.⁴ About 21% of babies born after extrauterine abdominal pregnancy have birth defects presumably due to compression of fetus in absence of amniotic fluid buffer. Typical deformities include limb defects, facial and cranial asymmetry, joint abnormalities and central nervous malfunction. There may be massive torrential bleeding during removal of placenta due to its adherence to vital organs with feeding vessels. It has been reported that unless the placenta can be easily tied off or removed it may be preferable to leave it in place and allow for its natural regression.² However, leaving the placenta in situ has been associated with increased post-operative morbidity and mortality and is thus not advisable. There have been many reports of advanced extrauterine

pregnancy that ended with a viable fetus and a healthy mother.²

CONCLUSION

This is a case report of an advanced extrauterine abdominal pregnancy that had likely originated in left non-communicating horn of uterus which ruptured and resulted in secondary implantation in abdominal cavity. The pregnancy continued uneventfully to full term and ended successfully with operative delivery of a healthy baby. The importance of this case report is that an extrauterine abdominal pregnancy could be missed during antenatal care despite repeated USG. Furthermore, the antenatal diagnosis of advanced extrauterine pregnancy does not necessarily justify the termination of the pregnancy since good maternal and fetal outcome is not uncommon. Pre-viable abdominal pregnancy prior to 21 weeks of gestation need immediate operative intervention but for viable pregnancies presenting after 24 weeks of gestation a more conservative approach is advocated provided the patient can be under strict observation preferably in a hospital.

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