CASE REPORT PROF-1429

SECONDARY ABDOMINAL PREGNANCY

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ABSTRACT... Secondary abdominal pregnancy is a rare form of ectopic pregnancy. A 21 weeks viable secondary abdominal pregnancy after tubal rupture has been found at laparotomy. The case is reported because of its rarity.

Key words: Ectopic pregnancy, abdominal pregnancy, extra uterine pregnancy.

INTRODUCTION

"Ectopic pregnancy" and "extrauterine pregnancy" refer to implantation of a gestational sac at any site other than uterine cavity. The most common sites of such pregnancy are the fallopian tubes, whereas the ovary and abdominal cavity are involved less frequently[1].

Abdominal pregnancy is a rare and potentionally life-threatening form of ectopic pregnancy. Approximately 1 percent of all pregnancies are extrauterine, and 1 to 3 percent of these are peritoneal implantations. It can be primary or secondary[2]. Presentation of primary abdominal pregnancy before the 12th week of gestation mimics an ectopic tubal pregnancy, except that the fallopian tubes feel normal during the pelvic examination. Diagnosis is suggested by abdominal pain, amenorrhea, vaginal bleeding or spotting, a positive pregnancy test, and confirmed by diagnostic aids.In literature, mentioned sites of primary abdominal pregnancy are the Pouch of Douglas, posterior uterine wall, uterine fundus, liver, spleen, lesser sac, omentum, and diaphragm. Most abdominal pregnancies are secondary which occur after the 12th week of gestation. They originate as tubal or ovarian pregnancies that rupture into the peritoneal cavity, where they reimplant[3].

Maternal and perinantal mortality associated with abdominal pregnancy range from0.5% to 18% and 40% to 95%, respectively[4].

CASE REPORT

Mrs. A. T. 25 years old primigravida married for 1 ½ year was admitted through emergency department on July 6, 2008.She gave history of 5 months amenorrhea with abdominal pain off and on for last two months. She started perceiving painful foetal movement for last 15days. At that time she remained admitted for severe abdominal pain at private clinic from where she was discharged after symptomatic treatment. There was no significant past and family history. On examination she was pale and afebrile. Pulse 90/min and BP was 120/70mm Hg. Abdomen soft, non tender, revealed fundal height corresponding to 20 weeks of gestation. No definite foetal parts were palpable. Pelvic examination showed closed uneffaced cervix without any bleeding.

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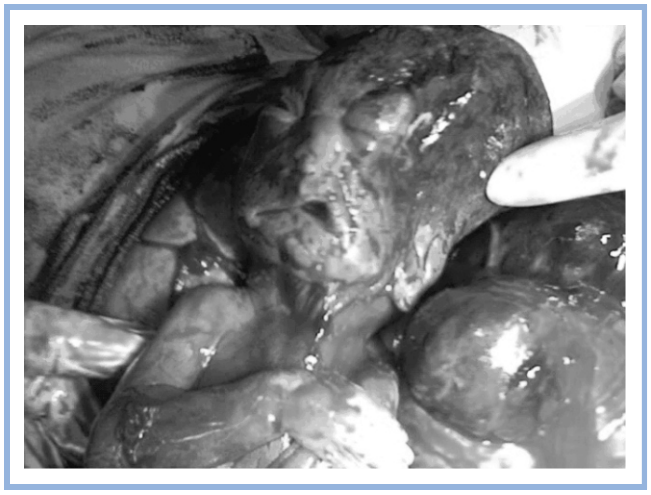
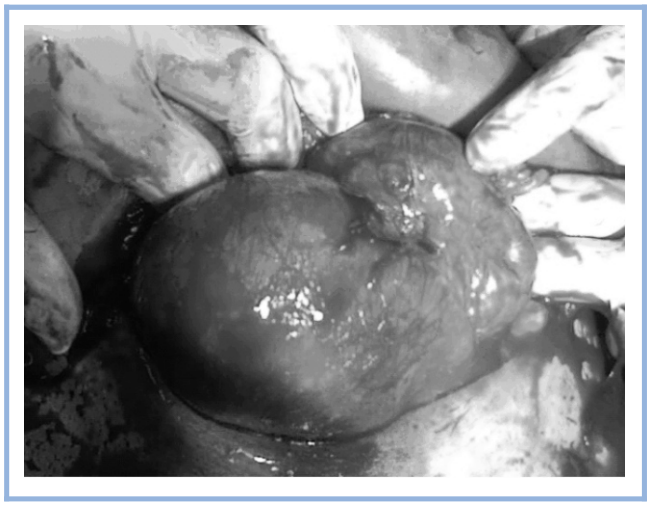


Uterus was 10 weeks size clearly separable from a mass on left side and Pouch of Douglas. One ultrasound report highlighted an alive foetus of 21-22 weeks size with oligohydramnios and an empty uterus. Two other sonologists reported an empty uterus and viable pregnancy of 22 weeks size occupying the left horn of uterus giving strong suspicion of bicornuate uterus. In all reports no free fluid was present in peritoneal cavity. Two units of blood transfused prior to surgery. Elective laparotomy was performed on July 8, 2008. There was insignificant free blood in abdomen. A live male foetus weighing 450gm, 15cm long, malformed, lying freely in left lower abdomen without any amniotic membrane. The umbilical cord (18cm long) was attached to a jumbled up mass of placenta, blood clots, left tube & ovary. Right tube & ovary were normal. Uterus was enlarged to a size of 10 weeks. Left tube & ovary along with placenta and blood clots were removed. Abdomen closed after moping the minimal amount of peritoneal blood. Recovery remained uneventful .Patient left hospital after seven days.



DISCUSSION

Advancing secondary abdominal pregnancy demands challenging situation diagnostically & therapeutically[5]. Patients with secondary abdominal pregnancy had frequent episodes of abdominal pain & vomiting in second & third trimester associated with painful foetal movements. Although it is an extremely rare variety of ectopic pregnancy, obstetricians dealing such cases must be aware of the condition[6]. Our patient might have been diagnosed one month earlier provided the clinical features were kept in mind .Ultrasonography plays a crucial role in early and correct identification of ectopic pregnancy[7] but has been shown to miss 50% cases of intra abdominal pregnancy[8]. As in our case we had three different sonological reports to cope with. The confusing diagnosis on ultra sonogram can be overcome if the features like abnormal relationship between foetus, uterus, placenta and amniotic fluid are kept in mind. Similarly unusual foetal lie, oligohydramnios and congenital malformations further point towards the suspicion of intra abdominal pregnancy[9]. Other diagnostic methods including plain x-ray abdomen and nuclear magnetic resonance imaging can be opted to

achieve accurate diagnosis and quick intervention to reduce severity of situation[10]. Maternal mortality & morbidity are directly proportional to separation of placenta from its site of attachment. If complete removal of placenta is possible, then it must be removed. If it is not feasible then placenta should be left in situ and treated by methotraxate therapy[11]. The above management was not taken in our case as placental separation was possible without risk of haemorrhage. The perinantal mortality is in the range of 85-95%[12]. It is because of increased occurrence of foetal deformities resulting from intra abdominal pressure which is not counter balanced by amniotic fluid and intrauterine environment[13]. When abdominal pregnancy is diagnosed, the widely accepted treatment is immediate laparotomy, for termination of pregnancy because of associated maternal and foetal risks[3,14].

We intervened earlier and terminated the pregnancy; if allowed to proceed the mortality would have been very high.

CONCLUSION

Although abdominal pregnancy is a rare occurrence; its early diagnosis and quick intervention is vital to reduce maternal and perinantal mortality& morbidity.

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