

CASE REPORT

Abdominal Pregnancy with a Full Term Alive Fetus

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ABSTRACT

Abdominal pregnancy with alive fetus at term is a rare condition. An obstetrician may encounter in life once such condition. A 35 years. Old lady presented in the labour room with severe abdominal pain and bleeding per vaginum. On clinical examination, she was diagnosed as case of scar rupture due to previous three caesarean deliveries. The Doppler ultrasound revealed intact abdominal pregnancy with alive fetus at term. Three units of blood were transfused. Laparotomy was done. Alive fetus female 3.2 kg was delivered from abdominal cavity from the pouch of Douglas. The placenta was complete having its blood supply from right uterine artery. It was completely removed. She had good recovery.

Key words: Abdominal pregnancy, Alive fetus, complete removal of placenta

INTRODUCTION

The First Entopic pregnancy was described by Abulcasis (936-1013 AD), an Arabic writer on surgical topics¹. Primrose in 1594, reported fist twin abdominal pregnancy. One twin was delivered by anterior abdominal fistula and 2nd by laparotomy². Parry had reported over 500 cases of abdominal/ ectopic pregnancies with 60% mortality at that time³. The incidence of abdominal pregnancy is 1: 10,000 birth and 1% of all ectopic gestations. It can be primary or secondary abdominal pregnancy. The sites of implantation of abdominal pregnancy are omentum, liver, ovaries, pouch of doughlas, and broad ligament⁴. The mortality rate can be as high up to 8% due to haemoperitonium⁵. The fate of abdominal pregnancy depends upon site of placental attachment The placental attachment at bowel, mesentry, and omentum usually present at 27-28 weeks due to complications. The placenta attached to adenexa as seen in this case and receiving blood supply from right uterine artery or uterine fistula usually leads to alive fetus at term. The preoperative accurate localization of placenta is very important to avoid incision in to the placenta during laparotomy.

CASE PRESENTATION

A 35 years old lady gravida 4 para 3 , with previous 3 caesarean sections was referred from Narrowal District with severe pain in abdomen and bleeding per vagina for the last 6 hours. On history, it was spontaneous conception , unsure of dates having no anteantant visits or routine check up by any doctor in the current pregnancy Her all caesarean sectons were done due to contracted pelvis . Her last child born was 4 years back . On examination she was pale, emaciated, blood pressure 100/ 60 mm Hg, pulse 120 per minute and all blood indices were depressed indicating severe anemia. Her abdomen was tender. lie was transverse and fatal parts weae palpable under the skin . The provisional diagnosis of placentaee previa or scar dehienisce was made The doppler ultrasound revealed abdominal pregnancy with 38+ 5 weeks of alive fetus .The placentaee was in right adenexa having its blood supply from right uterine artery. She was trasfused 3 units of blood. Special written consent was taken. The laparotomy was done under general anesthesia. The abdomen was opened by subumblical incision carefully to avoid incision in to placentaee. The membranes were intact. There was no haemopreitonium. The alive female fetus delivered with apgore score 8 at one minute and 10 at 5 minute with out any apparent anomaly. The placentaee were examined. It was completely attached with right adenexa having its blood supply from right uterine artery. It was completely removed .There was minimal bleeding. Both ovaries and tubes were intact .Bilateral tubal ligation was done. The uterus was adherent to anterior abdominal wall up to fundus. The abdomen was closed in layers. The patient had smooth recovery.

DICUSSION

The abdominal pregnancy is rare form of ectopic gestation with very high maternal and perinatal mortality. It is classified as primary or secondary according to studdiford criteria⁶. It is based on following criteria 1, normal tubes and ovaries 2, absence of uteroplacental fistula 3, exclusive attachment of pregnancy on peritoneal surface. This was case of secondary abdominal pregnancy because ovaries were intact. The incidence is high in developing countries probably due to high ratio of pelvic inflammatory disease, tubal sterilization, tubal reconstruction surgery, and pregnancy with intra uterine device⁷. The risk factor in study case was previous surgery. The lack of antenatal care, poverty, illiteracy and ignorance were probably other factors for such late presentation. The most common symptoms were chronic pain in the abdomen with constipation in our patient. These are well documented in the literature as abdominal pain (83%), abdominal pain with hypovolemic shock (13%) and vaginal bleeding in half of patients⁸.

Early diagnosis depends on high index of suspicion. The clinical features include painful foetal movements, weight loss, vaginal bleeding and uneffaced cervix. The ultrasound and MRI had definite role for confirmation of diagnosis and absolute localization of placenta to avoid catastrophic haemorrhage at time of laparotomy⁹.

The management of abdominal pregnancy is a difficult challenge. The widely accepted treatment is laparotomy due to haemoperitoneum and fetal congenital abnormality after diagnosis. There is considerable debate over conservative management if the fetus is alive and gestation is beyond 24 weeks¹⁰. This approach is only possible that patient should be kept under strict observation in hospital. The greatest threat is the removal of placenta at time of laparotomy. It is advocated that except the entire blood supply of placenta can be secured with minimal risk to patient otherwise it is wise to leave placenta in situ. The use of methotrexate and spontaneous autolysis has been reported but there is real risk of infection¹¹. The placenta were removed as complete because of its attachment. The bleeding was minimal. The most of cases of abdominal pregnancy present early due to haemoperitoneum or fetal demise¹². Full term pregnancy with alive fetus is really a rare one as seen in the studied case.

CONCLUSION

The antenatal and ultrasound services are essential at primary and secondary health services. The physicians at such level with limited capacity must be able to diagnose advanced abdominal pregnancy per operatively. The referral to tertiary care hospital must be quick to prevent maternal mortality.

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