CASE REPORT PROF-1065

FULL TERM SECONDARY ABDOMINAL PREGNANCY

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ABSTRACT ... In properly evaluated patients full term abdominal pregnancy can be managed, although advanced abdominal pregnancy is a complex condition demanding challenging management. This care report describes case of a young lady 35 years age who was diagnosed as a case of secondary abdominal pregnancy and was managed successfully.

Key Words: Laparotomy, Pregnancy, Ectopic, Abdominal.

INTRODUCTION

Abdominal pregnancy, a rare variety of ectopic pregnancy is defined as an intra peritoneal implantation exclusive of tubal, ovarian or intra-ligamentous implantation[1]. The world wide incidence ranges from 1:1320 to 1:10,200 births[1,2].

Abdominal pregnancy is of two types:-

1. Primary Abdominal Pregnancy

When ovum is implanted directly into peritoneal cavity. It is rare phenomenon with only 24 cases reported in world literature[3].

2. Secondary Abdominal Pregnancy

When pregnancy occurs initially in tube and later on tubal abortion occurs and foetus gets implanted in peritoneal cavity. Secondary abdominal pregnancy is more common. This condition is associated with high maternal mortality with reported rates of .5 to 18%[4]. The major cause for this is massive hemorrhage which may occur during pregnancy during surgery or in postoperative period. Similarly condition is associated with high peritoneal mortality rate of about 95%[2].

This is attributed to pre-term deliveries resulting from active intervention done in majority of cases as soon as diagnoses is made.

CASE REPORT

A middle aged lady presented in emergency labour room of gynae unit I Allied Hospital Faisalabad. She was a case of precious pregnancy conceiving after 14 years of marriage. She was having gestational age of 9 months (not sure of dates). She was having mild labour pains. There was no other significant complaint. On general clinical examination she was pale looking. On abdominal examination abdomen was tense and tender. Her fundal

height was greater than thirty six weeks. Fetal parts were difficult to palpate but fetal heart was audible. C.T.G was done it was reactive. The provisional diagnoses based on clinical findings was;

1. Rupture uterus
2. Abruptio placenta

But the clinical signs were not in favor of any of these provisional diagnosis as her vitals were well maintained and her CTG was reactive. Her base line investigations were within normal limits. U.S.G was done and she was diagnosed as a case of abdominal pregnancy. Blood was arranged and she was prepared for emergency laparotomy. On laparotomy there was a gestational sac outside the uterus. A nick was given in the sac and the baby was delivered with apgar score 6/10, 4/10. Baby had many compression deformities. Nose forehead and chest were compressed. Baby expired after half an hour. Later the placenta was localized, it was adherent to gut and omentum and so it was left in situ. Drain was placed in pouch of douglas and abdomen closed.

The patient had a remarkable recovery. Her base line beta H.C.G was sent. She was given injection methotrexate 50 mg/kg weekly. And her serial estimation of beta H.C.G was done. Her beta H.C.G showed a rapid decline within six weeks and her serial U.S.G showed complete resolution of placenta in three months.

DISCUSSION

The incidence of abdominal pregnancy in Pakistan was found to be 0.04% of total deliveries and 5.6% of ectopic pregnancies[5]. The major factor found was non availability of parental care.

It is usually easier to appreciate abdominal pregnancy on U.S.G examination at end of the first trimester when pelvic organs are best visualized. However presentation of cases at an advanced stage poses considerable diagnostic problems. The diagnostic errors in different series has ranged from 50 to 90%[6]. Infect MRI is a considered a gold standard for diagnosis[6]. A lateral x-ray of abdomen showing fetal parts over lying maternal spine may be help full. Similarly elevated maternal serum alpha feto protein have been associated with abdominal pregnancies esp with more extensive visceral implantation[7].

There has been some debate in management. The management of abdominal pregnancy diagnosed in first trimester or early second trimester in surgical intervention without delay. However, due to late presentation of cases, the condition may remain un diagnosed untill a viable stage of gestation. The major questions raised are related to timing and mode of delivery. Although no international consensus exists on issue, a conservative approach is proposed in absence of fetal gross malformation, placental implantation remote from upper abdomen, good maternal condition, close management in a tertiary care hospital of the patient previously informed of risks and outcomes[8]. Expectant management has been adopted in potentially viable pregnancies to gain fetal lung maturity. Similarly approach has been adopted in another tertiary care hospital of Pakistan and has produced an alive and healthy fetus[9]. Although an undiagnosed asymptomatic abdominal pregnancies may go to 38 weeks, for diagnosed abdominal pregnancy it is recommended that in absence of complications, laparotomy should be planned at 34 weeks[10].

Management of placenta in advanced abdominal pregnancy is still a matter of debate. Similarly no consensus exists on management of placenta and each case is managed on individual bases according to intra operative findings. Often placenta separates on its own after delivery of infant. However if it does not separate controversy exists whether it should be removed or left in situ. Massive hemorrhage may occur during its removal. The worst hemorrhage near to catastrophe has been reported by Ramachandran[4]. Leaving the placenta in situ with out attempting its removal is also not free of risks. Maternal morbidity and mortality is significantly higher when placenta is left behind. The follow up of placenta which is left in situ or partially removed is done

by serial B.H.C.G and sonograms[11].

Role of post operative methotrexate is currently controversial. However medicine is still favoured by some in dose of 50 mg/kg I.M for every three weeks for four cycles in combinations with preoperative arterial ambolization[12].

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