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Case Report

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ADVANCED ABDOMINAL PREGNANCY: A CASE REPORT

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Summary

This case report of rare and dangerous obstetric condition, advance abdominal pregnancy, includes the clinical presentation of the patient, pre-operative diagnosis and surgical management of such case with maternal survival in Basrah Maternity Hospital

Introduction

Abdominal pregnancy is a rare and dangerous condition with a high maternal mortality (2% - 20%)[1]. In the United States they are seen once every 10.000 birth and consist of approximately 1% of ectopic gestation[2].

The earliest description of an advanced abdominal pregnancy was recorded nearly one thousand years ago, and operative delivery with survival of mother and baby in such a case was accomplished by a swine in Switzerland in the year 1500[3].

Pre-operative diagnosis is often missed, usually because the rare condition has not been considered. Maternal history may be helpful, and previous pelvic inflammatory disease (PID) and ectopic pregnancy, together with abdominal discomfort in the absence of Braxton-Hicks contractions[4], may be a guide. Sonography, which has replaced abdominal film diagnosis, suggest the presence of an intra-abdominal pregnancy when an abnormal relation among fetus, placenta, amniotic fluid and uterus is noted[2]. However sonographic interpretation may occasionally be difficult because of distorted pelvic anatomy and/or overlying bowel gas. Recently, magnetic resonance imaging has been used in obstetric diagnosis, providing rather exact information regarding the relationship between the fetus, placenta, amniotic fluid, and uterus[5].

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Case Report

A 35-years old, gravida 6, para 5 women presented in the out patient department on 29/5/2001, with mild vaginal bleeding for the last three days. Her last menstrual period was unknown , but she has eight missed periods. She had mild. Lower, uncomfortable abdominal pain. She didn't feel fetal movements for the last three days.

Vaginal bleeding appeared in the first trimester, with nausea and vomiting and mild abdominal pain, which lasted for two days and was subsided spontaneously. Two weeks later slight vaginal bleeding appeared. Patient did not consult a doctor at that time. She experienced painful fetal movements.

She had five previous uncomplicated pregnancies, followed by a normal and uneventful purperium. The last delivery occuring 10 months before.

Her vital signs were stable, heart examination revealed normal double rhythm with no added sounds.

Abdominal examination revealed soft abdomen, no area of tenderness, easily felt fetal parts in transverse lie, head was in the maternal left side.

Ultrasound evaluation revealed a dead fetus of approximately 32 weeks gestation by measuring Biparietal diameter, transverse lie, head on the maternal left side, oligohydramnious and low lying placenta. A mass separate from the fetus was though to be the uterus, a finding suggestive but not diagnostic of an extrauterine pregnancy.

An X-ray films of the abdomen disclosed a single fetus in transverse lie, with other signs of fetal death. Under general anesthesia with oropharyngeal intubation, patient underwent surgery for suspected placenta previa totalis, transverse lie, a suspected abdominal pregnancy, a dead female baby weighing 1800 gm was delivered from an extrauterine thin walled sac, from broad ligament. There is very little amount of amniotic fluid and the baby had multiple compressive deformities on the left partial skull and left and right mandibles.

The placenta weighing 350 gm, was attached to the right side of broad ligament, to the mesentery of large bowel. The umbilical cord was ligated proximal to the placenta after delivery of the baby.

Complete removal of placenta was safely undertaken, after fine and easy separation at it's attachment to the mesentery of the large bowel.

The pedicles were clamped separately to the mesentery and broad ligament ligated with out any injury to the adjacent organs and the bowel. Average blood loss was 1000 ml during the operation. The uterus was bulky in size and separated from the extra uterine sac.

The mother was observed for the following 24 hours. She recovered rapidly and started oral feeding on the next day. She had normal bowel motion on the second post-operative day.

Despite the high maternal morbidity and mortality with this condition, mother survived and experienced fine and uneventful postoperative period, she was

discharged home in her eighth's postoperative day.

A follow up visit 4 weeks later revealed that was in excellent condition.

Comment

Early abdominal pregnancy is typically self-limited by hemorrhage from trophablastic invasion with complete abortion of the gestational sac, leaving a discrete crater that is sometimes difficult to identify[6] .

Advanced abdominal pregnancies, as in our patient, survive the hemorrhage of trophablastic invasion and implant secondarily during the first trimester on any adjacent structure.

The clinical picture of abdominal pregnancy is extremely variable, the most frequent signs and symptoms being abdominal (100%), vaginal bleeding early in pregnancy, persistent nausea and vomiting, general malaise, and painful fetal movement [4,5.]

A history of an acute, short lasting episode of abdominal pain in early pregnancy indicating a tubal accident is frequently recorded. Our patient had abdominal pain and experienced painful fetal movement.

There is a persistent abnormal fetal lie, fetal parts are readily palpated and the uterus much enlarged and may be felt separately from the fetus [1]. Our patient had abdormal fetal lie and fetal parts are readily palpated.

Radiographic films show maternal intestinal gases superimposed on the fetuse. U/S shows oligohydraminos and no clear out line of the gestational sac[1].

Our patient ultrasound examination has revealed oligohydramnios with transverse fetal lie and low lying placenta, a mass separated from the fetuse was thought to be the uterus a finding suggestive but not diagnostic of the extrauterine pregnancy because abdominal pregenancy is a rare event and pre-operative diagnosis may be difficult. Sonographic examination and more recently magnetic resonance imaging have proved helpful in the pre-operative diagnosis in patient who presented with advanced abdominal pregnancy.

Ninety-nine percent of all pregnancies are intrauterine. Of the 1% of pregnancies that are extrauterine, 98% are intratubal, 1% are ovarian and 1% are primary or secondary peritoneal implants [6].

Peritoneal pregnancies are classified as primary and secondary [7]. Primary implantation on the peritoneum is extremely rare in extrauterine pregnancy and is potentially life-threatening of ectopic pregnancy within the peritoneal cavity, representing a grave risk to maternal health. Secondary abdominal pregnancies are by far the most common and result tubal abortion or rupture, or less often, after uterine rupture with subsequent implantation within abdomen.

Early diagnosis and appropriate surgical management, regardless of stage of gestation, appear to be important in achieving good results [7].

Our case was of secondary peritoneal pregnancy, the concepts was implanted on the board ligament. Our patient underwent immediate cesarean section because of the suspicion of exreauterine with placenta previa to overcome placental separation, to avoid a massive hemorrhage and to decrease maternal morbidity and mortality rate. Because of high maternal mortality rate associated with such a case, the cause of death include massive hemorrhage and chronic blood loss[3]. The fetus should be delivered as soon as viability is achieved though perinatal loss is 75% or greater. The greater problem is whether or not to remove the placenta. In most cases, the placenta should be left because of the risk of uncontrolled hemorrhage, if it is removed. However if the placenta is left in-situ the morbidity from infection, abscess formation and adhesion is high,

but it is usually the procedure of choice, it must be matter of judgement of the individual operator.

Our patient in an attempt to avoid postoperative infection and adhesion, placenta removal was safely undertaken, because of the accessibility for ligation of maternal vessels supplying the area with out uncontrollable hemorrhage or injury to adjacent organs.

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