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ADVANCED VIABLE SECONDARY ABDOMINAL PREGNANCY: A RARE CASE REPORT

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ABSTRACT Advanced abdominal pregnancy is rare and accounts for 1 in 25,000 pregnancies. A 19 year-old primi gravida presented to the obstetrics department at 36 weeks gestation with a painful abdomen. Third trimester ultrasound showed "single live intrauterine fetus of 32 weeks 5 days, Amniotic fluid was severely reduced and gross somatic movement is reduced". On laparotomy ,it was turned out a secondary viable extra uterine pregnancy. Mother and baby was discharged in stable condition in spite of this catastrophic situation.

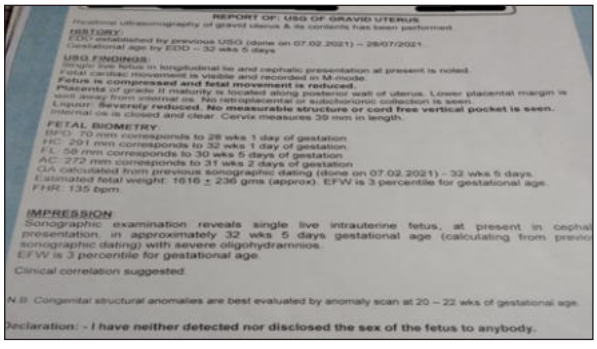
KEYWORDS : Advanced abdominal pregnancy, secondary viable extra uterine pregnancy

INTRODUCTION

Advanced abdominal pregnancy is rare and accounts for 1 in 25,000 pregnancies.[1] **Abdominal pregnancy** can be regarded as a form of ectopic pregnancy where the embryo or fetus is growing and developing outside the womb in the abdomen, but not in the Fallopian tube, ovary or broad ligament.[2,3,4] We report a rare case of a term viable abdominal pregnancy.

Case Presentation

A 19 year-old primigravida presented to the obstetrics department at 36 weeks gestation with a painful abdomen. She had a history of pain abdomen from second trimester. Basic investigations including ultrasonography was performed at second trimester and were within normal limits. Ultrasound showed "single live intrauterine foetus of 15 weeks gestation". Surgical causes of a painful abdomen were excluded. On examination, she was hemodynamically stable. The height of the uterus corresponded to 34 weeks gestation. Third trimester ultrasound showed "single live intrauterine fetus of 32 weeks 5 days, Amniotic fluid was severely reduced and gross somatic movement is reduced"(fig no 1) .


REPORT OF: USG OF GRAVID UTERUS

Realtime ultrasonography of gravid uterus & its contents has been performed.

HISTORY:
LMP established by previous USG (done on 07.02.2021) – 28/07/2021.
Gestational age by EDD – 32 wks 5 days.

USG FINDINGS:
Single live fetus in longitudinal lie and cephalic presentation at present is noted.
Fetal cardiac movement is visible and recorded in M-mode.
Fetus is compressed and fetal movement is reduced.
Placenta of grade II maturity is located along posterior wall of uterus. Lower placental margin is well away from internal os. No retroplacental or subchorionic collection is seen.
Liquor: Severely reduced. No measurable structure or cord free vertical pocket is seen.
Internal os is closed and clear. Cervix measures 39 mm in length.

FETAL BIOMETRY:
BPD: 70 mm corresponds to 28 wks 1 day of gestation.
HC: 291 mm corresponds to 32 wks 1 day of gestation.
FL: 58 mm corresponds to 30 wks 5 days of gestation.
AC: 272 mm corresponds to 31 wks 2 days of gestation.
GA calculated from previous sonographic dating (done on 07.02.2021) - 32 wks 5 days.
Estimated fetal weight: 1616 ± 236 gms (approx). EFW is 3 percentile for gestational age.
FHR: 135 bpm.

IMPRESSION
Sonographic examination reveals single live intrauterine fetus, at present in cephalic presentation, in approximately 32 wks 5 days gestational age (calculating from previous sonographic dating) with severe oligohydramnios.
EFW is 3 percentile for gestational age.
Clinical correlation suggested.

N.B. Congenital structural anomalies are best evaluated by anomaly scan at 20 – 22 wks of gestational age.

Declaration: - I have neither detected nor disclosed the sex of the fetus to anybody.

Figure 1: Ultrasonography Report Of Third Trimester

The patient was managed by an elective caesarean section. Intra-operatively, as the abdomen was opened, the foetus along with the placenta were found lying in the abdominal cavity densely adhered with omentum. A live late preterm baby boy of 2.370 kg was delivered .Baby did not cry after birth,needed tactile stimulation and positive pressure ventilation for 2 minutes.The Apgar score 4 at 1 minute and 5 at 5 minutes of birth. Baby was transferred to SNCU.

The placenta was attached with omentum mainly and some portion adhered with large intestine and right sided adnexa(fig no 2). Massive bleeding occurred during separation of placenta. The massive hemorrhage protocol was initiated. A general surgical consult was requested due to involvement of bowel. Clamps were given involving the pelvic adnexa structures and omentum to control the bleeding during separation. As the placenta could not be separated from the right adnexa, the placenta along with right fallopian tube were removed. The left tube and both ovaries were normal. Adhesiolysis from the colon was performed by surgery with minimal damage. Per and postoperatively, the patient received 3 units of packed red blood cells. Estimated blood loss was 2000 mL.

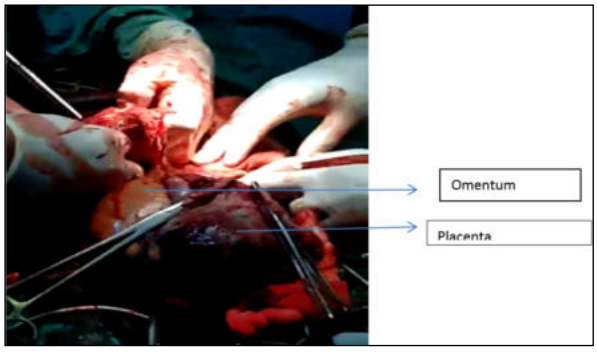


Figure 2: Intraoperative Picture Of Placental Separation From Omentum

The patient was then transferred to the HDU for further observation. Mother was discharged on 7th post operative day in stable condition.

The baby was transferred to SNCU for further management. Left hemifacial deformity, open wide and communicating anterior and posterior fontanelle, contracture of bilateral knee joints, CTEV in right foot were noted. MRI brain and USG whole abdomen and echocardiography appears normal and baby was discharged from SNCU in stable condition. On follow up after 6 weeks, baby is growing satisfactorily, gaining weight, knee contractures are loosening up. Manipulation for vertical talus has been started(fig no 3).

Figure 3: Viable Neonate On Day 20

DISCUSSION

The maternal mortality rate is 0.5 to 8%, and perinatal mortality ranges between 40% and 95% in abdominal pregnancy[5]. A very few case

report regarding live term advanced abdominal pregnancies have been reported so far. This case is being reported because of its rarity and uniqueness.

Diagnosis of abdominal pregnancy is very rare one and requires high degree of suspicion. Most cases can be diagnosed by ultrasound.[6] Our patient presented with abdominal pain and acute unexplained anaemia at 16 weeks of pregnancy and managed conservatively. Though ultrasonography was done, it misses the extrauterine pregnancy and excludes the diagnosis. Probably, this abdominal pregnancy is a result of secondary implantation from an aborted tubal pregnancy. To diagnose the rare primary abdominal pregnancy, Studdiford's criteria need to be fulfilled: tubes and ovaries should be normal, there should be no abnormal connection between the uterus and the abdominal cavity, and the pregnancy should be related solely to the peritoneal surface without signs that there was a tubal pregnancy first.[7] In our case right sided tube and ovary was involved. So it is confirmed as a case of secondary abdominal pregnancy.

After that, in course of pregnancy patient presented with pain abdomen multiple times and managed conservatively. In secondary abdominal pregnancy,ultrasonography can demonstrate that the pregnancy is outside an empty uterus, there is reduced to no amniotic fluid between the placenta and the foetus, no uterine wall surrounding the foetus, foetal parts are close to the abdominal wall, the foetus has an abnormal lie, the placenta looks abnormal and there is free fluid in the abdomen.[8] In this case, third trimester ultrasonography indicated that foetus is compressed and foetal movement is reduced with severe oligohydramnios but it was mentioned intrauterine pregnancy. During laparotomy, the diagnosis presented in a sudden and unprepared condition.

Bleeding from placental implantation site could be massive and life threatening and is often the most common cause of maternal mortality which can reach as high as 20–30%. The decision to remove or leave the placenta should depend on extent of the placentation particularly with the bowel and omental involvement as well as on the expertise of the surgeon. In this case, the placental involvement was with right adnexa along with portion of the colon. So, right sided fallopian tube and ovary was removed along with placenta, with minimal disturbance to colon serosa. Bleeding was controlled and managed. Uterus, left sided tube, ovary was preserved.

Dubinsky et al(1996) showed in a study that the survival rate of abdominal pregnancy is better than generally believed which is evident in this case report.[9]

CONCLUSION

The presentation of a pregnant woman with an unusual clinical picture, especially with recurrent abdominal pain with history of acute unexplained anaemia in association with painful foetal movements or intrauterine foetal death with failed induction of labour, should alert the obstetrician to the possibility of abdominal pregnancy. Expertly performed and interpreted ultrasonography may be the definitive diagnostic technique.

CONSENT

Informed consent was granted from the patient for presentation of this case report and images.

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Competing Interest

The authors declare that they have no competing interests.

Authors' Contribution

SG wrote the paper, and the manuscript was reviewed and edited by KG and MD. All authors approved the final version.

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