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RARE CASE OF SECONDARY ABDOMINAL PREGNANCY: A CASE REPORT

Obstetrics & Gynaecology

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ABSTRACT

Abdominal pregnancy is surgical emergency. Prompt diagnosis is essential for better outcome of patient . Diagnosis is generally made by symptoms which are amenorrhea, per vaginal bleeding, pain in abdomen , vomiting which can mimic ruptured ovarian cyst , corpus luteal hematoma. Herein we describe case of 22 year old with amenorrhea since 4 months , acute abdominal pain and vomiting with intrauterine pregnancy on prior USG .

KEYWORDS

Abdominal, Pregnancy, laparotomy, Prompt Diagnosis.

INTRODUCTION

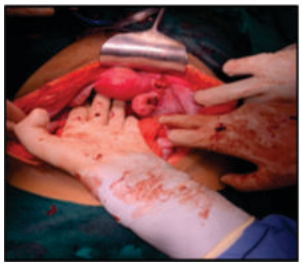
An Ectopic pregnancy is one in which fertilized ovum is implanted and develops outside normal endometrial cavity. Abdominal pregnancy accounts for 1% of ectopic pregnancy .It is rare after spontaneous conception . According to [1,2] the implantation site, classification encompasses the majority of 95% tubal location; the rest of 5% accounting for cervical, cornual, interstitial, ovarian, heterotopic, abdominal or cesarean-scar implantations [1]. The average incidence is about 1 in 3000 pregnancies. Use of ART is linked to increased risks for ectopic pregnancy.

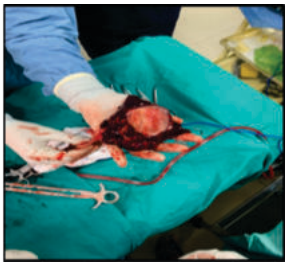
Case Report

A 22y/o G2A1 came to emergency department with c/o amenorrhea since 4 months, pain in abdomen since 2 and PV spotting since morning . Referred from Private hospital on O2 and noradrenalin support with h/o 1 PCV transfusion prior. On arrival P-120/min, BP-80/60mmhg on noradrenalin 6ml/hr, Spo2 – 99% on 2lit O2, RR-20, pallor present. P/A –tenderness present, guarding present . P/S- cx os closed,min altered bleeding present. Laboratory tests CBC- hb -9.1, TLC-45OOO plt- 2.1 lac . Rest labs were within normal limit. USG obs s/o- intrauterine IUFD of 15weeks. Patient was started on higher antibiotics, inotropic support. Patient deteriorated further with P-146/min with falling BP so decision of Exploratory Laparotomy was taken.

Surgical Management

Patient taken for Emergency Exploratory Laparotomy. Peritoneum opened – massive hemoperitoneum noted , intact amniotic sac with fetus with placenta arising from rent in right sided non communicating rudimentary horn seen. Bilateral tubes, ovaries were normal , adhesions between placenta and omentum noted. Rudimentary horn with placenta excised and right salphingectomy done. 6PCV and 2FFP transfused . Patient shifted to MICU -stabilized and discharged on POD 15.





DISCUSSION

An abdominal pregnancy can go undetected until advanced gestational age. The most common physical findings reported in literature are the following: abdominal tenderness (100%), an abnormal fetal lie (70%; breech, oblique or transverse), easily palpating the baby's parts on clinical examination, and a displaced uterine cervix (40%) [3,4,5,6]. On examination, there may be abnormal presentation, easily palpable fetal parts, uneffaced and displaced cervix and palpation of abdominal mass separate from uterus [8]. High index of suspicion is first step in the diagnosis. Increased maternal serum alpha feto protein levels add to the suspicion[7]. Ultrasonography and MRI are diagnostic modalities for confirmation of abdominal pregnancy [8] . Ultrasound will show empty uterus, absence of amniotic fluid between placenta and fetus, absence of myometrium between bladder and gestation and abnormal lie with fetal parts close to abdominal wall [9] . But sonographic diagnosis is missed in half of the cases [7]. Management of early pregnancy is laparoscopic removal . In advanced pregnancy urgent Laparotomy irrespective of gestational age should be done.

CONCLUSIONS

Abdominal pregnancy can be regarded as a difficult diagnosis to establish, with a greater chance in case of increased awareness. It is a very rare condition but it has high rate of feto-maternal morbidity and mortality, especially in the emergency ward and associated with advanced pregnancies. Timely diagnosis can result in better outcome of patient.

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