



Secondary Intra-Abdominal Pregnancy : A Case Report

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ABSTRACT Abdominal pregnancy is extremely rare, and has been historically defined as an implantation in the peritoneal cavity, exclusive of tubal, ovarian and intraligamentary pregnancy. Abdominal pregnancy can be primary or secondary. The presence of abdominal pregnancy is associated with increased maternal and perinatal morbidity and mortality. The reported incidence of abdominal pregnancy ranges from 1 per 2200 to 1 per 10,200 pregnancies¹. The early recognition and management of the same is necessary to prevent untoward complications. This case report describes an interesting case of a 30 year primigravida with a secondary abdominal pregnancy.

KEYWORDS

introduction

abdominal pregnancy is extremely rare, and has been historically defined as an implantation in the peritoneal cavity, exclusive of tubal, ovarian and intraligamentary pregnancy. the presence of abdominal pregnancy is associated with increase maternal and perinatal morbidity and mortality. it can be primary or secondary, with the latter being more common. approximately 1% of all pregnancies are extra uterine, and 1% to 3% of these are peritoneal implantations¹. the reported incident of abdominal pregnancy ranges 1 per 2200 to 1 per 10,200 pregnancies¹. advanced abdominal pregnancy is rare with a reported incidence of 1 in 22,000 pregnancies¹. the risk factor for abdominal pregnancy is the same as ectopic pregnancy, and when it is recognized immediate removal of the fetus from the peritoneal cavity is recommended. we report a case of secondary abdominal pregnancy of 20 weeks of gestation .

Case

An unbooked case of 30 years old primigravida, presented with 5 month amenorrhoea with pain abdomen for one week. There was no history of bleeding per vagina, dizziness or fever. Past history- patients married life was 13 years and patient was taking treatment for infertility for 4-5 years.

On examination, patient was average, pulse rate 86/min, BP 100/70. Per abdomen, examination revealed uterus 20 week size with no external ballotment. Hb-10.4gm/dl, platelet count and coagulation profile were within normal limit. USG show didelphus uterus with one cavity containing dead foetus. So according to USG findings, induction with dinoprost gel started, but there was no progress even induction from 2 days , finally patient was prepared for hysterotomy/laparotomy.

After opening abdomen by transverse incision, uterus was normal size, right sided tube and ovary was normal but on left side , ampullary part of fallopian tube was enlarged around 10x7 cm, which was clamped and cut, after opening this tubal mass, whole of the placenta was present in this, foetus lies outside the uterus and adhered to posterior wall of uterus, same was separated. Tubal mass and foetus sent for preservation. Drain kept in pouch of douglas and abdomen was closed in layers. One unit blood was given intraoperatively. Her postoperative period was uneventful. The foetal weight around 50 gms.

Uterus





Dead Foetus

Dead Foetus

Tube Containing Placenta

Comment

Approximately 50 % of ectopic pregnancy are missed at the time of initial presentation .Abdominal pregnancy is potentially life-threatening, with maternal and perinatal mortality rates of 0.5 % to 18 % and 40 % to 95% respectively ² . Rarely the embryo is expelled into the abdomen, the afterbirth remains attached to the tube and the embryo continues to live and grow. Such a condition is referred to as a secondary abdominal pregnancy . Primary abdominal pregnancy in which the fertilized egg attaches to an abdominal organ and ovarian pregnancies are rarer still, ultrasound ,MRI, CT scan and laparotomy are tools to distinguish between primary and secondary abdominal pregnancies. The patient with abdominal pregnancy typically presents with constant abdominal pain, progressive anemia and sudden loss of fetal movements.

During laparotomy the clinician is the one to make a decision regarding the fate of the placenta. Postoperative maternal morbidity will be lessened with the complete removal of the placenta ,provided it is technically feasible . If vascular attachment involves major blood vessels or vital structures, the organ should be left undisturbed ³. Retention of the placenta in situ is not without risks and postoperative morbidity . Postoperative methotrexate has been administered by some for resorption of the placenta, but it leads to accumulation of necrotic debris due to accelerated placental resorption and

associated morbidity ⁴. Secondary hemorrhage, abscess formation , paralytic ileus and bowel obstruction, have all been reported as the complications of leaving the placenta in situ . Resorption of placenta is a slow process and can be monitored by serial ultrasound ,CT scan and MRI.

However ,there is no definite consensus regarding the management of the placenta and each case should be individualized based on the intra operative findings.

Conclusions

proper preoperative evaluation, use of systemic methotrexate , assurance of sufficient blood products, availability of a multi-disciplinary surgical team and proper operative technique in managing abdominal pregnancy can reduce maternal morbidity and mortality .

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