ECTOPIC PREGNANCY AND FULL TERM LIVE BIRTH: A CASE REPORT

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ABSTRACT

Full term interligamentous pregnancy and delivery of alive healthy baby through laprotomy is a miracle. The clinical features are pain abdomen and amenorrhea. Ultrasonography in coreltion with beta HCG assay is the most valuable test of diagnosis. A 35 years old lady presented with amenorrhea 36 wks and abdominal discomfort. She had conceived after 10 years of secondary infertility. From clinical findings and ultrasound scan right broad ligament pregnancy was diagnosed. Laparotomy was done.A normal healthy baby was delivered.

Key words: *Broad ligament, Ectopic preganacy*

INTRODUCTION

Ectopic preganancy in broad ligament a retro peritoneal abdominal preganacy.it may result from primary or secondary implantation.Its incidence varies from 0.25 to 1.5 percent of all ectopic pregnancies[1, 2]. Women between 35 to 40 years of age have the highest incidence. Abdominal pregnancy is primary when Studdiford's Criteria is met i.e,:normal bilateral fallopian tubes and ovaries: the absence of utero-peritoneal fistula and that the pregnancy relates exclusively to the peritonail surface and early enough to eliminate the possibility of secondary implantation following an initial nidation in the tube.

Secondary abdominal pregnancy grows into the peritoneal cavity after its expulsion from its primary site of implantation. This type of pregnancy results from rupture of tubal pregnancy with the incidence being 1 in 10,000 births. Advance abdominal ectopic pregnancy is very rare the incidence being 1 in 25,000 to 30,000. Risk factors for abdominal pregnancies are tubal damage due to surgery, infection, congenital anomaly, endometriosis and luteal phasc disorder.

Due to risk of life threatening haemorrhage, immediate laparotomy and removal of fetus is recommended. Proper pre op evaluation and timely diagnosis is life saving. Pre op use of methotrexate and embolization can limit blood loss during surgery. Post op methotrexate is recommended but risk of infection due to placental necrosis is there. Any Attempt at removal of placenta will lead to torrential hemorrhage and may endanger the life of the mother. So placanta implanted on vascular structure like mesentery and vital organs should be left in situ.

CASE REPORT

A 35 years old Gravida 3 Para 2 with a history of conception after a period of 10 years of secondary infertility, presented to our out patients department with amenorrhea of 36 weeks. She was unsure of dates. There was no past history of any surgery etc i.e., she conceived spontaneously i.e with out taking medications for infertility. She had Abdominal discomfort throughout her pregnancy using ordinary analgesic and had no ultrasound in between. On general physical examination she was pale, but haemodynomically stable. Her fundal height was 36 weeks with tenderness and guarding present over the abdomen. Fetal parts were palpable as if feeling under the skin. Fetal lie was abnormal. On pelvic examination os was closed and cervix was displaced while uterus was felt to be Bulky and empty and lying to the left side of the fetus. Hemoglobin, blood group and ultrasonography were advised which revealed a normal fetus of 37 weeks gestation in the Right iliac fossa, liquor adequate and placenta implanted posteriorly. An empty enlarged uterus lying to the left of the fetus. Laparotomy was advised and blood was arranged. On opening the abdomen it was right broad ligament pregnancy. An alive

healthy female fetus with 9/10 Apgar score and weight 03 kg was delivered. Cord was shortened and ligated and placenta was left untouched and broad ligament was repaired. Her post operative course was eventless. She was later monitored for placental regression by ultrasound scan and β HCG assay for 02 years at 03 monthly intervals. One month after surgery the level of β HCG *was 395 miu/ml.* Three months later the level came to 250 miu/ml. She was given inj methotrexate 50 mg Intra muscular and on her next follow up visit the level of β HCG was not recordable. Overall on the regular future follow up visits in the Gynaecology and Obstetrics outpatient department, a mass in the right broad ligament (retained placenta) was present on ultrasound, although it was smoothly and gradually regressing. β HCG was not recordable.

DISCUSSION

Interligamentous pregnancy is a rare form of ectopic pregnancy that occurs in about 1 in 300 pregnancies[3]. An interligamentous pregnancy usually results from trophoblastic penetration of a tubal pregnancy through the tubal serosa into the mesosalpinx with secondary implantation between the leaves of broad ligament. These pregnancies can go undetected until an advanced gestational age may result in sever hemorrhage[4]. The rate of maternal mortality has been reported to be as height as 20%[5]. The perinatal motality rate ranges between 40-95%[6]. The site of implantation and availability of vascular supply are believed to be features that may influence the possibility of fetal survival[5]. The treatment of abdominal pregnancy is surgical extraction and to decide about management of placenta because that correlate well with maternal morbidity. Ligation of Cord and expectant, management, arterial embolisation and use of methotrexate to facilitate involution are different options[7, 8]. The complications of leaving the placenta in situ are in infections, secondary hemorrhage and intestinal obstructions. Once stable, patient with an abdominal pregnancy crossing 20 week of gestation, some gynecologists recommend conservative management till the age of viability with regular monitoring and keeping the haemodynamic status to optimum.

CONCLUSION

Proper pre op evaluation, assurance of sufficient blood product, availability of multi disciplinary surgical teams, proper operative technique and regular follow up can reduce material morbidity.

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