Case Report

AN ADVANCED ABDOMINAL PREGNANCY

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Abdominal pregnancy, a rare variant of ectopic pregnancy, is associated with a high perinatal and maternal mortality mainly because of partial separation of placenta and resulting haemorrhagic shock. In the case discussed, we did not come across any bleeding problems during surgery because of spontaneous resorption of placenta associated with foetal death. Most of the gynaecologists are of the view to leave the placenta undisturbed during surgery and to allow for its spontaneous resorption. The post operative course may be complicated because of infection, adhesions and intestinal obstruction. With the exception of febrile period of 5 days, our patient had an uneventful recovery period. She was re-admitted after 20 days, with complaints of vomiting. She was put on conservative treatment and investigated with a view to find out placental tissue but every thing was found out to be normal and she was discharged.

CASE REPORT

An eighteen years old lady, married for one year, reported to the ward in emergency with complaints of abdominal pain, nausea and vomiting, which started 5 days ago. She gave history of amenorrhoea of 32 weeks duration, which was followed by irregular bleeding per vagina about 18 days back. She went to a local doctor with the complaint of bleeding per vagina who performed dilatation and curretage (D&C). But after D&C she started having severe abdominal pain and was brought to labor ward in emergency.

On examination she was dehydrated, febrile and anaemic. On abdominal palpation she was tender with a palpable mass corresponding to about 28 weeks uterine gestation size. The mass could not be defined exactly because of muscle guarding. On vaginal examination, uterus was enlarged to about six weeks gestation with mild vaginal bleeding.

Consultant surgeon excluded any general surgical problem. Plain x-ray of abdomen showed distended bowel loops with evidence of foetal skeletal shadows which were overlapping the maternal spine and each other. Ultrasonographic examination of the pelvis revealed an empty uterus and a dead foetus lying out side the uterus in peritoneal cavity. A presumptive diagnosis of abdominal pregnancy was made.

On laparotomy, it was seen that a macerated foetus occupied peritoneal cavity to the right of uterus. It was lying in an enclosed space with adhesions to the surrounding gut, right broad ligament and pelvic peritoneum. Uterus was found to be

slightly enlarged.

Right tube and ovary could not be identified because of dense adhesions. Left tube and ovary were acutely inflamed. After delivering the foetus, a search for placenta was made in the surrounding gut, but no placental tissue was found. There was no evidence of ovarian or tubal tissue. A diagnosis of abdominal pregnancy was made.

DISCUSSION

Primary abdominal pregnancy is rare, and represents 1.6% of all ectopic pregnancies.[4] Incidence reported varies from one in 3000 to one in 15,000. Perinatal mortality is as high as 75%[3] and maternal mortality of 10% has been reported. Almost all cases of abdominal pregnancy follow early rupture or abortion of a tubal pregnancy into peritoneal cavity. The out come of pregnancy is usually foetal death or placental separation with intra peritoneal bleeding. A dead foetus if not recognized and removed immediately, may under go skeletonization, saponification, suppuration, abscess formation, or lithopedion formation.

The appearance of placental tissue in extra-uterine pregnancies depends upon disturbances of maternal, placental circulation and the state of viability of foetus.[1] At the time of laparotomy, it is generally recommended to remove foetus, membranes and cord and to leave the placenta undisturbed waiting for its spontaneous resorption. Attempts to remove the placenta can be made if pregnancy is early, and one is sure of ligating the blood vessels supplying the placental bed. Even in these circumstances Hypogastric and Ovarian artery ligation may be needed and sometimes hysterectomy and adnexal removal may be life saving.[2] Radiological examination and ultrasonography is useful in diagnosis of the condition, especially if the uterus is empty and both ovaries are visible. Oxytocin stimulation could be a valuable aid in the diagnosis of abdominal pregnancy, by noting absence of uterine activity when oxytocin is infused intra venously.[5] Once diagnosis is made prompt termination is necessary since partial separation of the placenta with hemorrhage occasionally occurs spontaneously in case of procastination.

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