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Case Report

# Early Primary Abdominal Pregnancy

Agarwal Namita[1], Naiknaware Sachin[1], Khadilkar Suvarna[2]

*[1]Chief Resident, [2]Asociate Professor and Unit Head*
*Department of Obstetrics and Gynecology, Saint George Hospital, Mumbai, India*

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## Case Report

Mrs. S, aged 27 years, $G_2P_1A_0$, having one alive and healthy child delivered 7 years back by cesarean section, presented to emergency unit of our hospital, with complaints of amenorrhea for one and half months and continuous pain in lower abdomen, giddiness, and bleeding per vaginum since one day. Her general condition was satisfactory, with pulse 100/min, BP 110/70 mmHg, and normal temperature. There was no pallor, and her respiratory system and CVS were normal. On per abdominal examination, there was minimal guarding and tenderness present, and no mass was felt. Per speculum examination revealed minimal bleeding through os. Vaginal examination showed that uterus was of normal size, anteverted, and cervical movements were nontender. Right fornix was clear, but in left fornix ill-defined tender mass of 3×3 cm was felt. Mild tenderness was present in left fornix. Laboratory investigations showed positive urine pregnancy test and serum ß-HCG levels of 1,600 IU/I. Her hemoglobin was 9.3 gm%, white cell count 13,000/mm$^3$, differential count of $N_{81}$, $L_{17}$, $E_1$, $M_1$, ESR 25 mm/hour, whereas the results for rest of the routine investigations were within normal limits. Ultrasound showed a large mixed echogenic left adenexal lesion of 6.2×3×5 cm$^3$ size with solid and cystic components, and large amount of free fluid in pouch of Douglas, suggestive of ruptured left ectopic gestation. Uterus was empty and of normal size, shape, and echo texture. Both ovaries were normal in size and shape. Emergency laparotomy was done which revealed ruptured gestational sac implanted on sigmoid colon, 200 cc of hemoperitonium was present. Products of conception and clots were removed. Part of the chorionic plate was firmly adherent to the bowel and was left behind to avoid bowel injury. Saline wash was given. Complete hemostasis was achieved. Tubercles were seen on anterior surface of uterus. Previous lower segment caesarean section scar was intact. The abdomen was closed after securing complete hemostasis. The patient withstood the surgery well. On postoperative day 8 ßHCG level was 380 mlU/ml and ultrasound of pelvis was normal. The patient was discharged on postoperative day 10. Follow-up of patient in outpatient department after 7 days of discharge showed ßHCG 34 mlU/ml. She was advised Anti Koch's treatment. Diagnosis of primary abdominal pregnancy was made according to Studdiford's criteria[1]. Both tubes and ovaries were in normal condition with no evidence of recent or remote injury. No evidence of uteroperitoneal fistula was found. The pregnancy was related exclusively to the peritoneal surface and was early enough to eliminate the possibility that it is a secondary implantation following a primary implantation in the tube.

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Correspondence:
Agarwal Namita
270, Jiwaji Nagar Thatipur,
Gwalior (M.P.), India.
Tel.: 0751-2342484,
E-mail: amitnamita1975@vahoo.co. in

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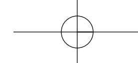
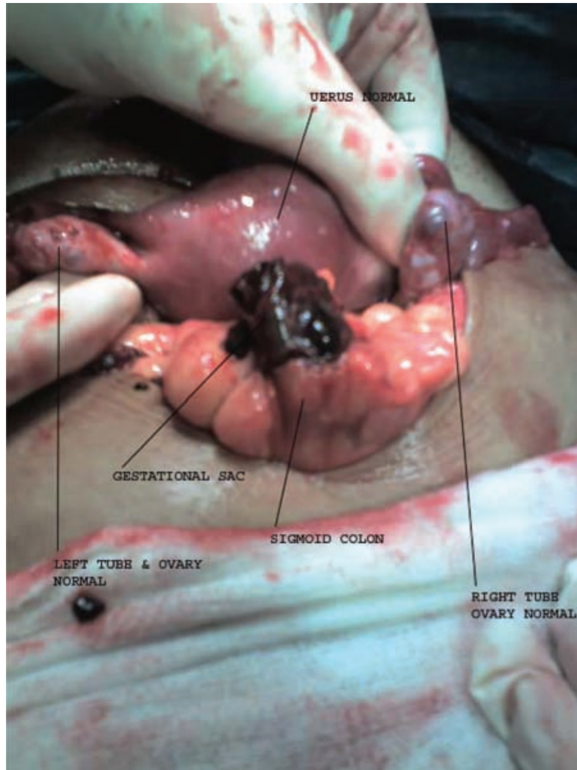
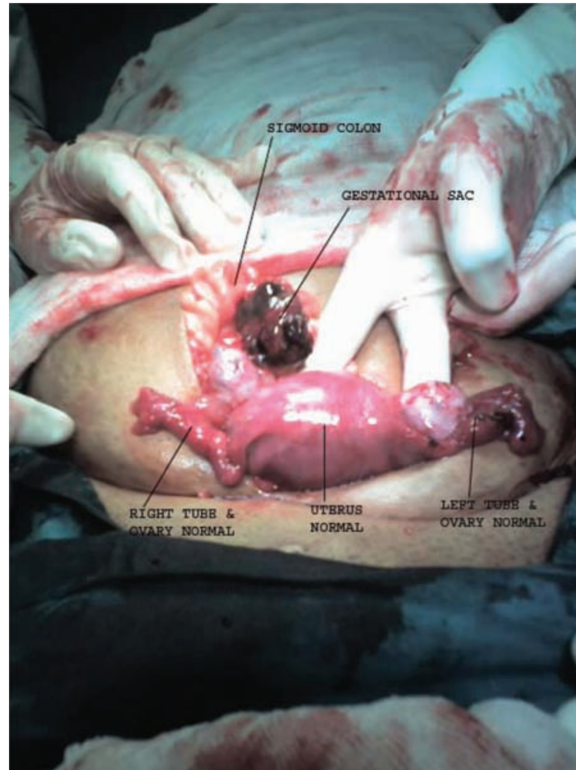






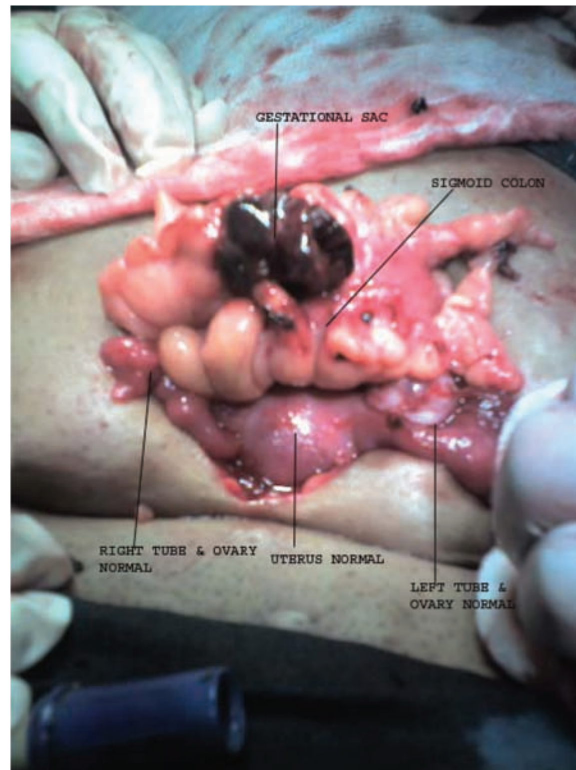
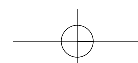




Fig 1-3: Intraoperative view showing ruptured gestational sac implanted on sigmoid colon with normal size uterus and bilateral tubes, ovaries intact.





## Discussion

Abdominal pregnancy is rarest of all types of extrauterine pregnancies. Report of the frequency of abdominal pregnancy varies from 1 in 3,371 deliveries and 0.03% of extra uterine gestation[1]. Today with high-resolution transvaginal sonography combined with highly sensitive test available for ßHCG, ectopic pregnancy diagnosis has shown a sensitivity of 93% and specificity of 99%[2]. Moreover, cases of advanced abdominal pregnancy that were diagnosed only at cesarean section have been reported[3]. A case of ruptured 10 weeks abdominal ectopic pregnancy originally diagnosed and treated as pelvic inflammatory disease was previously reported[4], thus highlighting differential diagnosis of abdominal pregnancy as pelvic inflammatory disease. A case of primary omental pregnancy was reported, which was preoperatively diagnosed as ruptured tubal pregnancy. Only after surgical exploration it was diagnosed as primary omental pregnancy, as bilateral tubes and ovaries were intact[5]. Even in our case transvaginal sonography could not diagnose the exact site of ectopic gestation. It was diagnosed only through exploratory laparotomy. The gestation sac was seen implanted on sigmoid colon and bilateral tubes and ovaries were intact.

Primary implantation of extrauterine pregnancy is extremely rare and is a potentially life-threatening variation of ectopic pregnancy, representing a grave risk to maternal health, because of high incidence of pelvic abscess, peritonitis, sepsis, massive rectal bleeding, or rectal passage of fetal bones secondary to the formation of celointestinal fistula[1]. In abdominal pregnancy rupture seldom occurs in general peritoneal cavity, as the site is sealed by inflammation and adhesions[6], but in our case the patient presented earlier with ruptured ectopic pregnancy in peritoneal cavity, may be because of absence of inflammation and adhesions. Thus by early intervention and prompt management maternal morbidity and mortality was prevented.

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