



Viable abdominal pregnancy

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Introduction

The incidence of ectopic pregnancy is 1-2% of which 95% are tubal¹ and 1-4% abdominal². For an abdominal pregnancy to reach advanced stage of gestation with viable fetus is very uncommon.

The diagnosis of abdominal pregnancy is difficult. Common presentation is abdominal pain, gastrointestinal symptoms, painful fetal movements, abnormal presentation, uneffaced and displaced cervix, and vaginal bleeding. In early gestation, there is a pelvic mass distinct from the uterus. The diagnosis can be further assisted and confirmed by x-ray, ultrasound or MRI. The maternal mortality is 5-18% and perinatal mortality 40-90%³. It is more common in multigravidas and elderly. When the fetus reaches term the spillage of meconium in the peritoneal cavity causes meconium peritonitis. Complications following this peritonitis can delay diagnosis and further lead to increase in maternal morbidity and mortality.

Case report

A 23 year old G₂P₁L₀, with unknown gestation period was admitted on 6th June, 2004 as an emergency with breathlessness, vomiting and vaginal bleeding. On examination she was distressed and pale. Her pulse rate was 150/minute, blood pressure 130/90 mmHg, and respiration rate 80/minute. Breath sounds were decreased and basal crepitation was present. On abdominal examination the fetus was in transverse lie and the uterus of 34 weeks size. She had with her a report

of sonography done outside on the same day which showed a 34 weeks fetus in transverse lie with posterior low lying placenta covering the internal os and no liquor amnii. A diagnosis of adult respiratory distress syndrome with transverse fetal lie was made and she was admitted in the ICU. While awaiting for reports of routine investigations, which later on showed no abnormality except a Hb of 8.89g/dL, she complained of abdominal pain (spurious labor). Fetal heart rate was 160/minute. As her condition was worsening it was decided to deliver the baby abdominally which was done on 7th June, 2004 under spinal anesthesia. There was ascitis and a live female baby smeared with meconium lying in the peritoneal cavity was taken out. The placenta was stuck to the left cornu of the uterus with a broad pedicle, was getting blood supply from it, and was encased by the omentum. The placenta was completely removed by omentectomy without damaging surrounding organs. The baby weighed 2.3 kg and was kept in the neonatal intensive care unit on ventilator, and was weaned off the ventilator by the 5th day.

The mother did well during the postoperative period except that on the 10th day there was wound gaping involving skin and subcutaneous tissues. After secondary suturing done on the next day there was good healing and the mother was discharged with the baby on 20th day. The baby was still under treatment for septicemia but the mother took away the baby against medical advice. She did not report for postnatal followup and was not seen again.

Discussion

The incidence of abdominal pregnancy is increasing in both developed and developing countries due to assisted reproductive techniques⁴ and due to poor utilization of medical resources⁵. Some undiagnosed tubal pregnancy may abort and later form abdominal pregnancy. Only 11 cases reported in the last 10 years could be found on Medline search for 'Secondary abdominal pregnancy reaching viable state.' In

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our hospital, this is the first case reaching viability in the last 10 years out of the 24,485 deliveries with 124 ectopic pregnancies.

Management of advanced abdominal pregnancy poses a great challenge in best of hands as it is associated with severe blood loss. In our case there was further complication of meconium peritonitis. This led to reactive pneumonia and respiratory distress of the mother which further complicated diagnosis and treatment. She was taken up for surgery inspite of ASA III risk due to tachypnea and tachycardia.

The placenta being stuck to the cornu of the uterus with a broad pedicle may possibly be due to the secondary abdominal pregnancy resulting from a rupture of cornual pregnancy even though the patient failed to give any history of abdominal pain in the 1st trimester. Unless all the blood supply to the placenta can be ligated it is best to leave the placenta in situ and do a follow up with serum β hCG levels. Injection methotrexate can be given for faster and complete absorption of the placenta. This can however lead to excess necrosis resulting in infection and abscess formation besides toxicity

due to the drug itself. The patient needs to be followed till complete absorption of the placenta.

There is a high incidence of congenital abnormality in the fetus and many fetuses do not survive till term.

Our patient did not have any further immediate complication after the delivery of the baby except wound gaping.

Referemces

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