

A RARE CASE PRESENTATION- SECONDARY ABDOMINAL PREGNANCY?***Dr. K. Mangala Lakshmi, Dr. G. Rohini, Dr. E. Shanthi and Dr. Meenakshi**

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ABSTRACT

Abdominal pregnancy is a type of ectopic pregnancy. Patient presents with symptoms of ectopic pregnancy. We are presenting a case of secondary abdominal pregnancy and its presentation, diagnosis and management.

KEYWORDS: Abdominal pregnancy, MRI, laparotomy.**INTRODUCTION**

Ectopic word is derived from meaning “abnormal position”. Hence, Ectopic pregnancy is defined when pregnancy occurs outside the uterine cavity. Types of ectopic pregnancy: Extrauterine (Tubal 90-95%, Ovarian 1%, Abdominal 1-2% very rare) Uterine (Interstitial, Rudimentary horn of Bicornuate uterus, cervical 0.5%, caesarean scar) Abdominal pregnancies are rare.^[1] Incidence of abdominal pregnancy is 1% of all ectopic pregnancies, ranges between 1:10000 pregnancies and 1:30,000 pregnancies.^[2] It can be either primary or secondary abdominal pregnancy. The growing embryo becomes implanted into the peritoneal cavity, and around the amnion a false membrane is formed and the pregnancy grows in the new site following attachment of the placenta with the neighbouring structures and a new vascular connection is established. Patient may present with abdominal pain or vaginal bleeding. Ultrasound help in diagnosis in 40% of the cases. But MRI is the best modality of choice. A MRI cannot only diagnose an abdominal pregnancy, but also locate the position of the placenta, which will significantly contribute to the development of treatment principles and a surgical treatment plan.^[3] Abdominal pregnancy is easily missed and mostly diagnosed after substantial emergency bleeding, which is caused by an insecure abdominal pregnancy placenta, a weak gestational sac, and the lack of protection of the myometrium.^[4]

Surgical removal of fetus either through laparotomy or laproscopically is the treatment of choice.

2. CASE REPORT

- Mrs.x, 33 year old. G3P2L2, booked case previous normal delivery with 3 months of amenorrhoea, came with complaints of bleeding PV since 1day. No h/o abdominal pain. Regular menstrual cycles. Married since 9 years. Previous pregnancies- all antenatal and postnatal events were uneventful. She is Rh

negative, hence Anti D was given. In this present pregnancy patient came with bleeding PV at 9 weeks and admitted in view of threatened abortion, found to be anemic with hemoglobin 6.4 gms. Hence transfused one packed cells. On examination, patient was conscious, oriented, mildly anemic, vitals were stable. Systemic examination were normal. Per abdomen was soft. Per speculum, cervix was healthy. Bimanual examination – os closed and mild bleeding PV +



Figure 1: Ultrasound showing gestational sac in the pouch of Douglas.

To confirm the diagnosis, Magnetic Resonance Imaging was done.

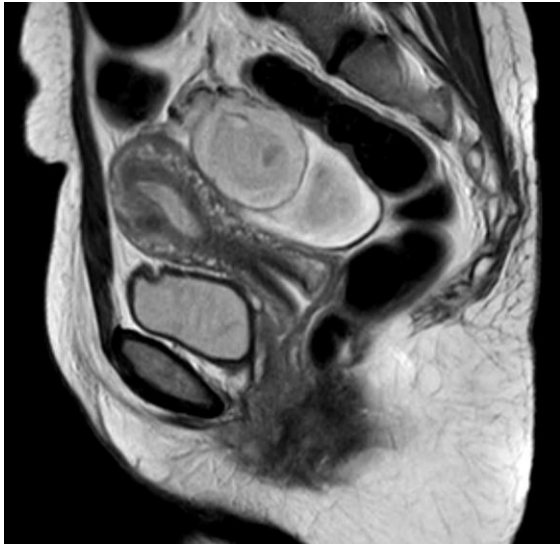


Figure 2: MRI.

Procedure

Patient was posted for Diagnostic Laparoscopy. Under General Anaesthesia patient was kept in lithotomy position, 10mm umbilical port made. Intra op findings: POC with intact gestational sac was seen in the pouch of Douglas and adherent. Hemoperitoneum and clots were present hence converted to lapotomy. Abdomen opened through suprapubic transverse incision. 300 ml of hemoperitoneum removed. Gestational sac with live fetus insitu removed from Pouch of Douglas.

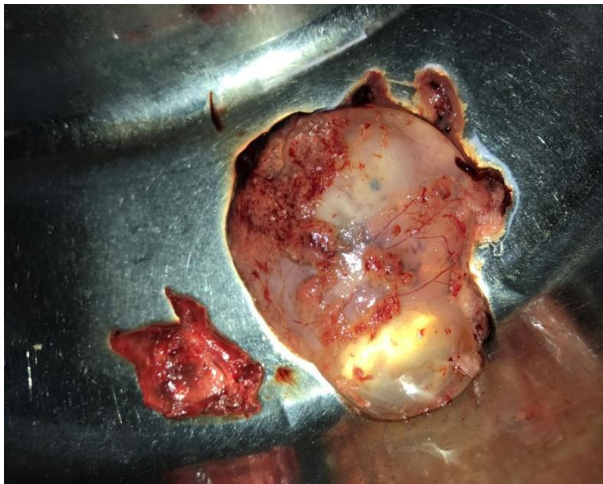


Figure 3: Showing intact gestational sac with live fetus.

Left fimbria and tube dilated and hyperemic, probable site of ectopic pregnancy. Left ovary – normal. Right tube and ovary- normal.

Bilateral salpingectomy done. Post op events were uneventful. Patient general condition was good during the follow up.

DISCUSSION

Abdominal pregnancy leading to a full term healthy newborn is very rare. It may be difficult to diagnose, but

once diagnosed, appropriate and timely intervention must be done since it might lead to many life threatening complications like rupture, intraperitoneal hemorrhage from the placenta may be seen which might be dreadful for the patient.

Treatment depends on the gestational age like conservative or surgical.

Hence correct diagnosis, treatment methods, preoperative preparation and post operative follow up is needed. A multidisciplinary approach should be done at the proper time.

Consent: We have obtained the patient's consent for the case report.

COMPETING INTERESTS: We do not have any commercial association that might pose a conflict of interest in connection with the manuscript. We certify that neither this manuscript nor one with a substantially similar content under our authorship has been published or is being considered for publication elsewhere.

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