Abdominal pregnancy : A rare presentation of ectopic pregnancy
Sultana N, Wazed F, Begum R, Begum N

Introduction
Abdominal pregnancy is a variety of ectopic pregnancy defined as an intra peritoneal implantation exclusive of tubal, ovarian or intraligamentary sites of implantation. It is rare with an incidence of 1: 10,000 births and 1: 100 ectopic pregnancy.1 Advanced abdominal pregnancy is associated with high maternal mortality (0-20%) and perinatal mortality (40-95%).1,2 Close monitoring with modern techniques result in a 70-80% increase in the survival of fetus older than 30 weeks. Though very rare, delivery of a term living abdominal pregnancy has been reported. More than 90% of the survivors have serious malformations.3 The Diagnosis of abdominal pregnancy may be difficult from a normal pregnancy. Ultrasonography of both abdominal and transvaginal scanning together with β hCG estimation has made early diagnosis.4 More recently combined ultrasonogram and Magnetic Resonance Imaging (MRI) is emphasized for accurate diagnosis of late abdominal pregnancy cases.5 An undiagnosed abdominal pregnancy which progressed to near term may be asymptomatic. The inability to stimulate uterine contractions with Oxytocics, is one of the indirect clues for this diagnosis.6 A case of abdominal pregnancy with dead fetus of about 28 weeks pregnancy is described here.

Case report
Mrs. Salma, 25 year old woman, gravida 3rd, para 2+0 (first one Stillbirth by Caesarean Section & second one normal term delivery at home, age of last child 4 years) was admitted into an urban primary health care centre (Maternity) with 7 months pregnancy (LMP could not be mentioned), sudden severe pain and moderate pervaginal bleeding 13 days back and loss of foetal moment for 13 days. She had no antenatal check up also.

On examination, uterus was about 28 weeks size, Fetal heart sound was not audible. Pervaginal examination revealed Cervical os closed and tubular. Ultrasonogram was done & it showed missed abortion.

Attempt was made to evacuate the Uterus. Pervaginal tablet Cytomis (200 µgm, 6 hourly) was given for 2 days. But there was no response. Then intracervical Foley's catheter was given for induction of abortion. Both these measures failed to initiate contraction of uterus. Then a second USG was done which confirmed abdominal pregnancy. It revealed uterus was 4.7x10 c.m. bulky, there was mild collection of fluid within the uterus. There was a cystic area with a fetus and placenta within the abdominal cavity in left lumber region. BPD-5 cm, FL-5.1 cm, Sex-female, Wt-600kg & placenta was attached with urinary bladder.

Then laparotomy was done. On laparotomy an intact amniotic sac was seen within the peritoneal cavity outside the uterus, surrounded by intestinal coils and omentum. Omentum was highly vascular, but vessels were thrombosed. During manipulation membranes were ruptured, liquor was found altered colored.

A dead female baby was taken out. Placenta was found attached with omentum & to a small part with coils of intestine in left side. Placenta

Dr. Nasreen Sultana, MBBS, FCPS (Obs & Gynae)
Assistant Professor, Obstetrics & Gynaecology
Department,
Dhaka National Medical College & Hospital
e-mail: snasreen35@yahoo.com

Dr. Feroza Wazed, MBBS, DGO, (Obs & Gynae)
Assistant Professor, Obstetrics & Gynaecology
Department, DMCH

Dr. Rashida Begum, MBBS
Medical Officer & Sonologist, Shimantik Urban Primary Care Project, Dhaka

Dr. Nurjahan Begum, MBBS
Clinic Manager & Sonologist, Shimantik Urban Primary Care Project, Dhaka

The ORION Medical Journal 2010 Jan; 33(1):735-736
was separated & removed intact. Bleeding was moderate. Uterus was bulky, Fallopean tubes were apparently normal.

Baby was about 30 cm in length, weight was about 650 gm and there was no other abnormality. The brain matter of the baby was liquefied. A drain tube was kept in situ. After peritoneal toileting, abdomen was closed in layers.

The post operative period of this patient was uneventful. Drain tube was removed after 24 hours and patient left the hospital on 5th day in good health. But patient was not available for follow up.

Discussion

In this paper we have reported a case of an abdominal pregnancy, which was a non booked case, identified at about 28 weeks of gestation. Abdominal pregnancy is described as early as 6 weeks and advanced weeks near term.\textsuperscript{6,10} This type of pregnancy usually occurs secondary to tubal abortion or rupture and reimplatation in omentum or mesentery. Some authorities doubt, primary abdominal pregnancy ever occurs but well documented cases are present.\textsuperscript{7} Risk factors are pelvic infections, previous pelvic surgery, ectopic gestation, caesarean section, past & current use of intrauterine device, congenital anomalies, endometriosis, infertility.\textsuperscript{8,9}

Mrs. Salma had history of caesarean section during her first childbirth followed by home delivery about four years back. This abdominal pregnancy may be secondary to tubal abortion or rent in the previous caesarean site. The usual events of tubal ectopic pregnancy are as follows: After few weeks fetus is extruded out from the abdominal ostium or break in the tube wall does not die as its chorionic attachment and amniotic sac remain intact. The chorion grows through the rent and forms attachments to the pelvic peritoneum, broad ligament, uterus, omentum, intestine. These structures react by developing large blood vessels to serve the placenta and their anatomy becomes grossly disturbed. The fetus grows in the peritoneal cavity, its amniotic sac becoming supported by an outer coat of organized lymph and blood exudates. Placental attachment is insecure, local decidual reaction weak, so retro placental and intra abdominal hemorrhage occurs.

Some abdominal pregnancy proceed to term when spurious labour ensues, uterus contracts and some dilatation of cervix occurs, discharge of blood and decidua occur, fetus die and undergoes maceration and other changes occur.

Our patient experienced pain and bleeding per vagina at home. Probably fetus became dead during that time as she subsequently felt no fetal movement. Then she was admitted in the urban comprehensive clinic.

On admission ultrasonogram failed to detect this, rather it diagnosed as a case of missed abortion. Subsequently when induction of abortion failed by Misoprostol and Foley's catheter, repeat Ultrasonogram identified it. Similar observations were described by other observer's also.\textsuperscript{5,11}

A time honored treatment for abdominal pregnancy following its diagnosis is surgery, excluding any attempt in the majority of the cases at extraction of the placenta, which is left in situ. This is mainly because in many instances, the placenta is attached to vital organs or vascular sites which could be seriously damaged during placental separation. One study, no serious complications occurred when it was left in situ.\textsuperscript{14} Color Doppler imaging & measurement of serum beta hCG were successfully used to follow the placental involution. We could remove the whole placenta easily as all the vessels were thrombosed & there was only moderate bleeding. Clinical management of advanced abdominal pregnancy has changed in recent years with adoption of more conservative
approach with improvement of perinatal outcome and developed countries.

**Conclusion**

Every woman of reproductive age should seek advice from a doctor or other health service provider as soon as possible after her missed period. It is essential for location of pregnancy and overall fetal well being if she is diagnosed pregnant by Ultrasonogram. To decreased maternal morbidity and perinatal mortality rates, accurate and early diagnosis of abdominal pregnancy is necessary. Therefore early Ultrasonogram should be advised by obstetricians.

**References**