



Primary Omental Pregnancy Masquerading as Acute Abdomen: A Case Report

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Introduction

The incidence of ectopic pregnancy is 1.5 to 2%. It poses a great threat to maternal life. Though 95% of ectopic pregnancies are tubal, the rest may present in ovaries, cervix or abdomen. Omental pregnancy is a rare form of abdominal pregnancy. It is of two types: Primary and secondary. In primary omental pregnancy, the embryo gets implanted in the omentum whereas in secondary type the embryo reaches omentum after rupture from the tube or ovaries or from an uteroperitoneal fistula [1].

Case Report

A 32-year-old gravid 2 para 1, previous history of vaginal delivery was admitted to Emergency department of IPGME&R hospital, Kolkata with complaints of lower abdomen pain and giddiness. History revealed that she had missed menstruation by one week and no contraceptive use. On examination, the patient was hypotensive and pale with diffuse abdominal tenderness. USG showed fluid in cul-de-sac with suspected right sided tubal ectopic pregnancy (? ruptured). Urine pregnancy test was positive on admission. An exploratory laparotomy was done for suspected ruptured ectopic pregnancy. On opening the abdomen, 1000 ml was haemo-peritoneum was found and drained. She was transfused two units of blood during surgery. Uterus, bilateral tubes and ovaries were normal. There was no evidence of uteroperitoneal fistula. This led to exploration of upper

abdomen. A hard mass was felt in the umbilical region. On further exploration, a thickened and nodular, highly vascular omentum with areas of hemorrhage and blood clots was found (Fig. 1). On careful dissection, a gestational sac with embryo was found cocooned in the omentum (Fig. 2). Partial omentectomy was done [2]. Histopathology showed villus formation, gestational sac and vascular structures in adipose tissue (omentum). Her post-operative period was uneventful.

Discussion

Ectopic pregnancy is the implantation of the blastocyst outside the lining of endometrial cavity. Tubal ectopic pregnancy contributes 95% of the ectopic pregnancies. Implantation in other sites like ovary, cervix, abdomen, rudimentary horn constitutes the remaining 5% of these. With the advent of ultrasound and β hCG, the diagnosis of tubal ectopic has become easier. Still, the diagnosis of non-tubal ectopics poses serious difficulty for the radiologists. This is where diagnostic laparoscopy gives the surgeons a better hand at clinching the diagnosis. When there is a high suspicion of ectopic pregnancy with normal adnexal findings, a thorough exploration of the abdomen is of utmost importance [3].

Studdiford's criteria has been used for the diagnosis of primary abdominal pregnancy. The salient features of this criteria are (i) normal tubes and ovaries (ii) no evidence of uteroperitoneal fistula (iii) presence of pregnancy exclusively on the omental surface.

In our case, pre-operative diagnosis was rupture tubal pregnancy with intra-peritoneal hemorrhage. Laparotomy was preferred to laparoscopy as the patient was hemodynamically unstable. On opening the abdomen, around 1 L of blood was drained but inspection of adnexa showed normal tubes and ovaries with no evidence of uteroperitoneal fistula. This led to exploration of upper abdomen when a hard indurated omentum was palpated. The abdomen incision was extended laterally to gain more access to the omentum. On

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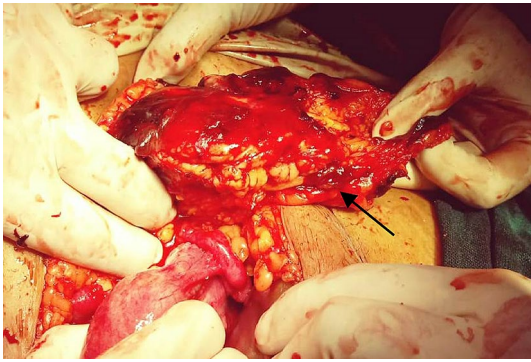


Fig.1 Indurated omentum with blood clots over the surface



Fig.2 Gestational sac with embryo seen after dissection

inspection, clots were noted on the surface of the omentum, and a defect was identified. Exploration with forceps revealed a gestational sac with embryo trapped within the omentum. Partial omentectomy was done to remove the indurated omentum. Weekly urine β hCG was done and turned negative on third week ensuring complete removal of trophoblastic tissue [4].

Ultrasound combined with clinical evaluation has 50% sensitivity in diagnosis of abdominal ectopic pregnancy. β hCG is not reliable on making a diagnosis but it can be used

to follow up of successful treatment. Hence when in doubt we should not restrict our boundaries to the pelvic organs alone.

Conclusion

Omental pregnancy is a rare event. What the mind does not know the eyes do not see. So, a very high suspicion of omental pregnancy is required for successful treatment. This case highlights the need for clinicians to explore beyond the routine whenever in doubt. This said, there is need for gynaecologists to constantly familiarize with the structures in the upper abdomen to avoid catastrophic surprise during surgeries.

Declarations

Conflict of interest The authors declare no conflicts of interest.

Informed Consent Written informed consent was obtained from the patient for publication of this case report and accompanying images.

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