ADVANCED ABDOMINAL PREGNANCY WITH A LIVING BABY

(A Case Report)

by

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Introduction

Abdominal pregnancy is one of the rare varieties of ectopic pregnancy and a living baby in such cases is still rare.

We are presenting a case of full term abdominal pregnancy in a primigravida, continuing upto term and resulting in a living baby without any congenital defect.

CASE REPORT

Mrs. M. B. aged 19 years Po + O married for 3 years, was admitted on 15-8-78 at 7.35 p.m. as a referred case of transverse lie with antepartum haemorrhage from Subdivisional hospital, 24-Parganas. She had no antenatal check-up during her pregnancy.

Menstrual History: L.M.P.? E.D.D.? Said to be carrying 9 months. Past Medical and Surgical history—Nothing particular.

O/E—G.C.—thin built, pulse/respiration 88/20/min. Blood pressure—100/70 mm of Hg. Hb—9 gm%.

P/A—Abdomen was enlarged to about 36 weeks size of pregnancy, iregular in outline. Outline of uterus could not be made out properly. Foetal parts were superficially palpable. Head was on the left hypochondriac region and F.H.S. were high up at the level of xiphisternum, 140/min. regular. Bleeding +.

Provisional Diagnosis—

(1) Transverse lie with antepartum haemorrhage. (2) Ruptured uterus. (3) Advanced abdominal pregnancy.

Operation: Abdomen was opened by right paramedian infraumbilical incision. On opening the peritoneal cavity the amniotic sac was visible through which foetus was seen beautifully floating in transverse lie with dorsosuperior position. A small nick was made in the amniotic sac and the fluid was sucked out and the baby was delivered. It was a mature female baby weighing 3 kg. 200 gms. which cried at birth. Uterus was found slightly bulky and bicornuate with right horn bigger than left. Right tube and ovary were normal and attached to right horn. Left tube and ovary were adherent to the placenta. The placenta was adherent to the intestine, omentum and pouch of Douglas. It was separated from the above structures without much difficulty. Placenta and membranes were removed. Weight of the placenta was 1 kg. 500 gm. Left sided salpingo-oophorectomy and appendicectomy were done as the appendix looked pathological, was about six inches long and adherent to the placenta. Abdominal cavity was carefully inspected for bleeding. There was slight oozing from the raw surface which was checked by hot pack.

Internal examination was done after operation. Vaginal examination showed os—1 finger dilated; uterus was bulky and a soft mass was felt on the right side of the body of the uterus which was the right horn. Blood with mucoid discharge was present.

Blood loss was minimum but prophylactically one bottle Gr. O Rh + ve blood was transfused.

Post operative period was uneventful and the

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patient was discharged on 9th postoperative day with healthy baby.

Mother and baby attended postnatal and well baby clinic after 6 weeks and 6 months—doing well.

H.P. Report—Placenta like mass—section shows normal placenta.

Cord like mass—Section shows structure of fallopian tube.

H.S.G.—Report shows uterus with only right fallopian tube; peritoneal spillage++.

Discussion

The usual cause of abdominal pregnancy is tubal rupture or tubal abortion. In this case evidence of tubal rupture could not be properly detected due to adhesions but the tube was densely adherent to the placenta. There is a possibility of slow rupture of tube and subsequent secondary abdominal pregnancy.

In emergency cases it is very difficult to diagnose the case as secondary abdominal pregnancy. In our case provisional diagnosis was transverse lie with antepartum haemorrhage or rupture uterus but the general condition was against ruptured uterus. Third provisional diagnosis was secondary abdominal pregnancy as foetal parts were superficially palpable and position of foetal heart sound was high up, but patient did not give any history of acute pain in the abdomen or digestive disturbance during her pregnancy. Emergency X-ray or X-ray with sound in uterus was not possible. On the other hand, transverse lie with antepartum haemorrhage and presence of foetal heart sound and vaginal bleeding required immediate laparotomy. During laparotomy diagnosis of secondary abdominal pregnancy was confirmed.

Very seldom cases come under observation while the child is still alive. The proper procedure in such cases is to operate at once, although there is a possibility that the child may present anatomical defects. According of Lay, in 50% cases there are congenital anomalies in the babies due to abnormal surroundings and placental insufficiency. Among those born alive the early mortality is very high. In 112 instances collected by Sittner (1955), 50 died in the first 4 weeks, and 14 before the end of first year, giving the mortality for first year of life of about 60%.

Regarding removal of placenta opinion varies. In our case placenta could be separated easily and removed.

Advanced abdominal pregnancy with a viable baby has been recorded by Kobak (1955). Oumachigni *et al* (1978) reported a living baby (2.35 kg) by laparotomy, but baby died after 24 hours due to atelectasis of both lungs. King (1954) reported a living baby by abdominal section at 40 weeks. In the present case the baby was alive without any congenital abnormalities and was followed up upto 6 months.

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See Figs. on Art Paper I