A SUCCESSFUL ABDOMINAL PREGNANCY

by

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SUMMARY

A Full term living Abdominal Pregnancy. A healthy Female Baby was born by Laparatomy. Both Baby and Mother are well.

Introduction

Abdominal pregnancy is one of the most rare and yet most serious forms of extra-uterine gestation. The incidence varies among different races and probably influenced by socio-demographic factors. In a large series from charity Hospital in New Orleans the incidence was I in 3379 births (Beacham *et al*, 1962).

Secondary abdominal pregnancy denotes extrauterine pregnancy which is continued in abdominal cavity after primary implantation in tube or the Ovary (Jeffcoate, 1972). From all available records and literature perhaps it is the only one in Bangladesh in which the foetus survived, perfectly healthy and also the mother is in good health. At the same time it is one of the rarest incidence in Medical Science so far received throughout the world. This type of pregnancy may be intraligamentry or intraperitonial (Meclead and Read, 1955).

A full term healthy living baby in extra-uterine environment is extremely rare and to diagnose the condition before operation is really a difficult job.

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Any case of advanced abdominal pregnancy is potentially hazardous with a maternal mortality in the region of 10 per cent (Beacham *et al*, 1962) and a foetal loss of 70 per cent (Tan *et al*, 1962) pressure deformities may occur in up to 40 per cent of viable infants (Tan *et al*, 1969). For the management of placenta it is generally advised that when the blood vessels can not be ligated the removal of the placenta should not be attempted.

Case Report

Mrs. K., a 35 years old female, Gravida-7 Para-6, was hospitalised on 19th February 1985 complaining amenorrhoea, intermittant adbominal pain for about last 40 weeks duration. She also complained of nausea, vomiting and general weakness. There was no vaginal bleeding. At about 2 months gestational period she felt severe abdominal pain and fainting and was treated by several local doctors. She recovered and gradually signs and symptoms of pregnancy appeared. The patient could not tell exactly the date of her last menstrual period but her cycle were regular. She presumed that her expected date of delivery had already passed by some days and for that reason mainly she took admission in Hospital (Fig. 1).

Her past Medical and Obstetrical histories were unremarkable. She felt painful foetal movements for the last few months.

The height of the Uterus was found to be asymmetrical and different from normal full term pregnancy. The physical examination was otherwise within normal limits. X-Ray of the

abdomen done in both A.P. and lateral view showed over-lapping of the foetal skull bones over the maternal spines which was highly suggestive of abdominal pregnancy and the lye of the foetus was transverse.

We further did special investigation like Ultrasonogram (Fig. 2) and the report was suggestive of ectopic pregnancy—the foetal head and body lying transversely with head directed to the left lateral side.

Then a few hours before the date of laparotomy on the 25th February 1985 we have done Hysterosalpingography (Fig. 3) and by that existence of a living foetus out side the Uterus was confirmed.

After Hb% estimation (50%) and proper grouping and cross matching, 3 pints of blood of A.B. Group was ready for transfusion during operation on 25th February 1985 (Fig. 4).

Laparotomy was done by routine right paramedian incision and after opening of the peritoneum a loose translucent sack consisting of omentum found covering the foetus—and omental sack was continuous with placental membranes.

Incising that sack and membranes one healthy Female baby was delivered out, the cord was trimmed as short as possible and the placenta left in situ as it was covering the great vessels of the posterior abdominal wall.

A drainage tube was inserted in the left illiac fossa which was removed after 48 hours, the uterus was enlarged upto 20 weeks pregnancy and was below the foetus supporting it like a cushion. The abdomen was closed in layers. There was no undue blood loss. And surprisingly there was no pressure deformity of the baby. It was perfectly a normal healthy female baby weighing 6000 grams, biparietal diameter 9.7 CM (Figs. 5 & 6).

Her post-operative convalescence period was uneventful and there was no discharge through drainage site and lochial discharge was normal (Fig. 7).

See Figs. on Art Paper IV, V