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Secondary Abdominal Twin Pregnancy – A Case Report

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Majority of the cases of abdominal pregnancy follow early rupture or abortion of a tubal pregnancy into the peritoneal cavity. The incidence varies from 1 in 3337 to 1 in 25000 births. Assisted reproductive procedures, induced abortion, endometriosis, tuberculosis and intrauterine devices contribute to an increased incidence of ectopic pregnancy. Fetal viability is extremely precarious, with a perinatal loss of 75 to 95 percent. Hence, treatment is required for maternal indications as it can cause torrential abdominal haemorrhage. The diagnosis of abdominal pregnancy is often missed because it is not considered.

Mrs. X, a 25 years old $G_3P_2(1/1)A_0$ was admitted at Pt. B.D. Sharma PGIMS with 4 months amenorrhoea, severe anemia and pain in abdomen. The pain was diffuse, dull and not associated with vomiting, fever or bleeding per vaginum. However, there was one episode of acute abdominal pain at 6 weeks gestation which subsided by itself. The patient had not had quickening.

General physical examination revealed severe anemia and jaundice. On abdominal palpation, a 24 weeks size, slightly tender, immobile mass arising out of the pelvis was present in lower abdomen. Fetal parts were not palpable and an abdominal massage did not excite any uterine contraction. A per vaginum examination revealed a closed cervical os and a large multiparous uterus posterior to the mass felt per abdomen. A possibility of secondary abdominal pregnancy was kept in mind.

Complete hemogram revealed haemoglobin level as 5.4 gm%, reticulocytes as 8% with a dimorphic blood picture. Her blood group was O positive, serum bilirubin measured 5mg% and urine was positive for bile pigments. Blood was negative for Australia antigen. Sonography of the abdomen revealed a twin abdominal pregnancy of 15 weeks, both the fetuses being in the same sac (Fig 1).

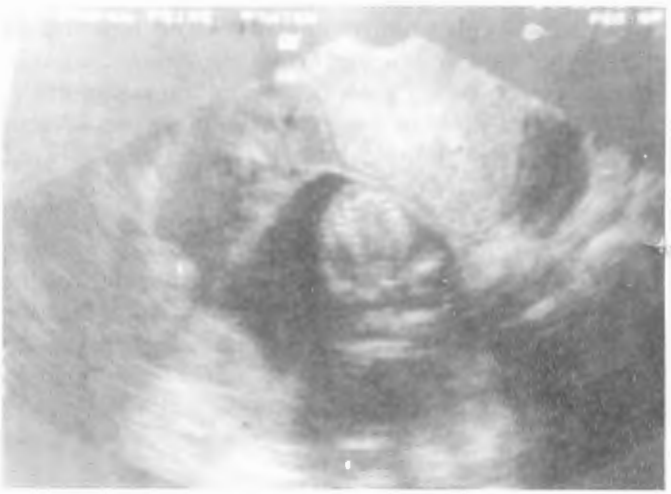

Fig. 1: Ultrasonic photograph showing the uterus separate from the twin pregnancy.

The patient was investigated. Four units of blood were transfused and then she was taken up for laparotomy. On opening the peritoneum, the membranes were found covered with omentum containing dilated blood vessels. In the process of separating the omentum, the sac got ruptured and two (monoamniotic) fetuses were delivered (Fig. 2). The placenta was single and most of it could be removed from the bed of the sac which was formed by the uterus and gut while omentum covered the sides and anterior surface. Profuse haemorrhage from the bed followed. The cavity was packed and blood transfused (3 units). The fallopian tubes and ovaries could not be identified in the bloody field. Packs were removed and haemostasis achieved. Abdomen was closed over a

corrugated drain.

The postoperative period was uneventful. Serum bilirubin gradually decreased to 2.2 mg%. Histopathology of the placenta revealed no pathological change. The patient was discharged on the 7th postoperative day.

Fig. 2: Twin fetuses being delivered from a monoamniotic sac at laparotomy.