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Case Report

A Live Intra Abdominal Pregnancy : A Case Report

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Abdominal pregnancy is a potentially life threatening form of ectopic gestation with an incidence of 1.4% of all the ectopic pregnancies and 1:3300 to 1:10200 of all the live births. Even more uncommonly does it reach an advanced age of gestation and a viable fetal outcome is indeed a rare event. This case report is of a 22-year-old primigravida with 34 weeks of abdominal pregnancy managed successfully with delivery of a live fetus.

Introduction

About 2% of all pregnancies are ectopic accounting for 10% of all pregnancy related deaths[1]. More than 95% of ectopic gestations occur within the fallopian tubes[1].

Abdominal pregnancy is much more uncommon with an incidence of 1 in 13,300 to 1,10,200 live births (1.4% of all ectopic pregnancies)[2].

Primary abdominal pregnancy has been described in a variety of extrapelvic organs including omentum, liver, spleen and small and large interstine[3]. A viable live fetal outcome is extremely rare[4].

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Case report

A 22-year-old primigravida with a history of 8 ½ months amenorrhea presented with pain in the abdomen since 2 days.

She was admitted in the hospital on 05/04/06. On examination abdomen was unusually tense and tender. Fundal height of the uterus was not appreciable but fetal limbs were palpable more easily than usual. Fetal heart sounds were well heard. Pelvic examination revealed uneffaced, undilated cervix.

The initial two antenatal ultrasonography examinations done earlier, reported a single, viable fetus with gestational age of 16 weeks and 28 weeks respectively. The ultrasonography repeated on admission revealed a bulky uterus with no intrauterine pregnancy but a single live extrauterine fetus with 30-32 weeks gestational age lying in the peritoneal cavity on the left side. Placenta was visualized in the right iliac fossa. Fetal cardiac activity was 156 beats/minutes.

Exploration laparotomy was undertaken on 06/04/06. After opening the peritoneum, a live fetus was found lying on the left side. Placenta was in the right iliac

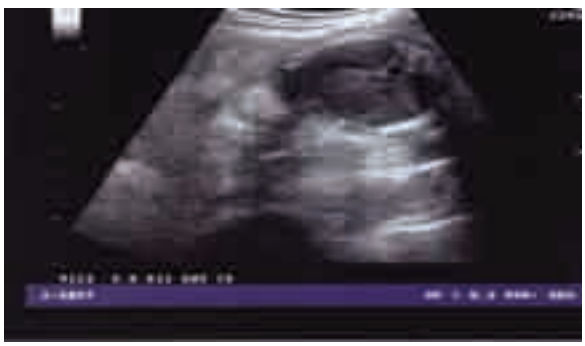

Fig.1 Fetal abdomen-surrounded by bowel loops

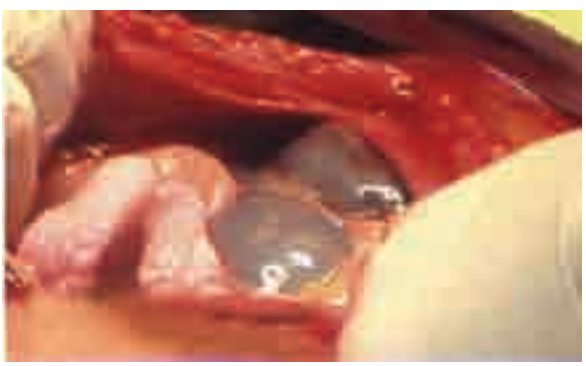

Fig.2 Fetus lying in the abdomen

Fig.3 Fetus delivered out

fossa. It was lying over the omentum and adherent to rudimentary horn of the uterus. The uterus was in the pelvis. After delivery of the fetus the cord was clamped. Placenta was separated with partial omentectomy. The newborn was thoroughly screened by the neonatologist and found to be premature with severe IUGR with no congenital anomalies. It weighed 800g and had Apgar scores of 2 at birth and 6 after 10 minutes. The baby was shifted to NICU. Mother was discharged on 16/04/06 and the baby was discharged from the hospital on 27/04/06. As the patient was a migrating laborer, she was later lost for follow up.

Discussion

Abdominal pregnancies are those in which implantation occurs within the peritoneal cavity excluding tubal, ovarian or intraligamentous sites of implantation. Such pregnancies are potentially life threatening with maternal mortality 7.7 times higher than that associated with intrauterine pregnancy[5]. Viable, advanced abdominal pregnancies are very rare and only a few sporadic cases have been reported in the past 10 to 15 years[4].

The incidence of abdominal pregnancy now appears to be increasing in both developed and developing countries; in the developed countries due to increasing use of assisted reproductive technology[6] and in the developing countries, particularly in rural areas presumably due to the restriction of human resources and diagnostic facilities and poor utilization of medical care by pregnant women[7].

As the diagnosis of abdominal pregnancy is often missed even with routine ultrasonography examination[8], every clinician should have a high index of suspicion for this condition. In a patient with amenorrhea, signs and symptoms such as abdominal pain, gastrointestinal disturbances, painful fetal movements, abnormal presentations, uneffaced cervix, vaginal bleeding, and syncope should arouse suspicion of ectopic pregnancy especially abdominal. For accurate preoperative diagnosis, CT scan and MRI have been used successfully[1]. A lateral x-ray showing fetal parts overlying maternal spine is also helpful[1].

Optimal management requires careful evaluation and planning. Generally speaking for previable abdominal pregnancies i.e prior to 24 week of gestation, immediate operative intervention is indicated but for viable pregnancies presenting after 24 weeks of gestation a more conservative approach is advocated provided the patient can be under strict observation preferably in a hospital[8]. Maternal and perinatal mortality of abdominal pregnancy is very high, about 0.5-18% and 40-95% respectively[1].

References:

1. Martin JN Jr, Sessums JK, Martin RW et al. Abdominal pregnancy: current concepts of management. *Obstet Gynecol 1988;71:549-57.*

2. Morita R, Tsusumi O, Kuramochi K et al. Successful laparoscopic management of primary abdominal pregnancy. *Hum Reprod 1996;11:2546-7*.

3. Cormio G, Santamato S, Vimercati A et al. Primary slpenic pregnancy: a case report. *J Reprod Med 2003;48:479-81*.

4. Sapuri M, Klufio C. A case of advanced viable extrauterine pregnancy. *PNG Med J 1997;40:44-7*.

5. Atrash HK, Friede A, Hogue C. Abdominal pregnancy in the United States: frequency and maternal mortality. *Obstet Gynecol 1987;69:333-7*.

6. Scheiber MD, Cedars MI. Successful non-surgical management of a heterotopic abdominal pregnancy following embryo transfer with cryopreserved-thawed embryos. *Hum Reprod 1999;14(5):1375-7*.

7. Zvandasara P. Advanced extrauterine pregnancy. *Cent Afr J Med 1995;41:28*.

8. White RG. Advanced abdominal pregnancy - a review of 23 cases. *Iran J Med Sci 1989;158:77-8*.