

# Advanced Secondary Abdominal Pregnancy: Still an Occurrence in Modern Medicine

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## Abstract

Advanced abdominal pregnancy is a rare event occurring once in every 25,000 births. We report a case of advanced abdominal pregnancy misdiagnosed as placenta previa. 28-year-old G4P3L3 was referred to us on 31 Jan 2008 with history of 8 months of amenorrhea and intermittent pain abdomen. Examination revealed an apparent uterine size of 34 weeks gestation with the fetus in transverse lie. Ultrasonography revealed a single live intrauterine pregnancy of 32 weeks with transverse lie with central placenta previa with oligohydramnios. She was treated conservatively. After 13 days of hospital stay, she complained of loss of fetal movements. Ultrasonography revealed an intrauterine death with transverse lie and central placenta previa. In view of central placenta previa, she was taken up for LSCS. A dead fetus of 2.1 kg of term maturity was present in the amniotic sac in the abdominal cavity. The placenta was attached around the left fallopian tube. The left ovary was also embedded in the placenta. Right-sided fimbriectomy with left-sided adnexectomy was done, removing the placenta along with adenexa. Postoperative period was uneventful.

**Keywords:** Advanced abdominal pregnancy, Placenta previa.

## INTRODUCTION

Advanced abdominal pregnancy is a rare event occurring once in every 25,000 births.<sup>1</sup> In a world bewildered by spectacular advances in imaging technology, the early detection of an abdominal pregnancy should be a feasible objective. Despite the almost ubiquitous usage of prenatal ultrasonography, extrauterine pregnancy may not be detected in a timely manner unless attention to basic ultrasonography is followed.<sup>2</sup>

We report a case of advanced abdominal pregnancy misdiagnosed as placenta previa.

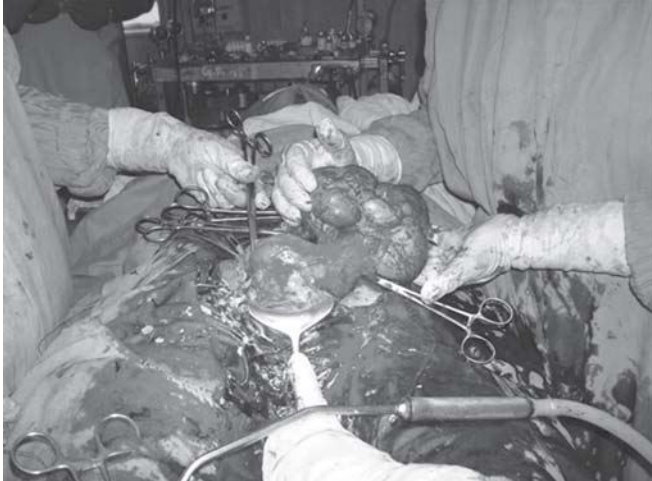
## CASE REPORT

A 28-year-old G4P3L3 was referred to us on 31 Jan 2008 with history of 8 months of amenorrhea and intermittent pain abdomen. Patient had antenatal check-ups prior to admission and was diagnosed as central placenta previa on ultrasonography. Her prior pregnancies were uneventful. Patient was not sure of her LMP.

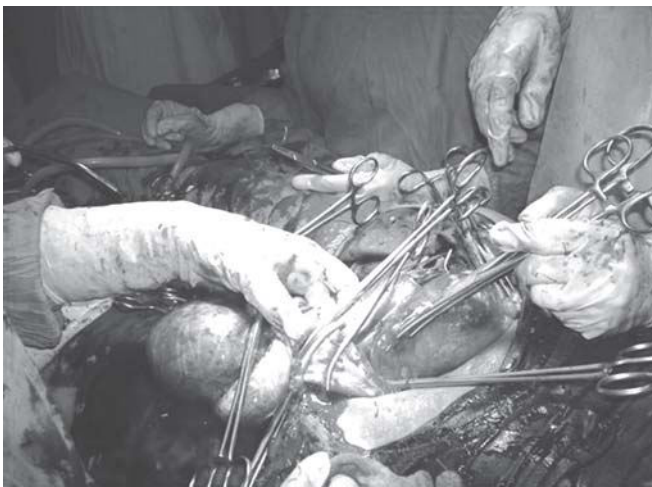
On examination, she was anemic; her pulse rate was 100/min and BP was 120/80 mmHg. The apparent uterine size was 34 weeks with transverse lie. FHR was 140/min. Her Hb was 7.8 gm% and blood group and Rh type AB + ve. Ultrasonography revealed a single live intrauterine pregnancy of 32 weeks with transverse lie with central placenta previa with oligohydramnios. She was treated conservatively. Anemia was corrected with hematinics. On 13 Feb 2008, she complained of loss of fetal movements.

Ultrasonography revealed an intrauterine death with transverse lie with central placenta previa.

In view of central placenta previa, she was taken up for LSCS. The operation was done under spinal anesthesia; abdomen was opened with pfannenstiel incision. As the rectus muscle was split, parietal peritoneum was visualized above the meconium stained amniotic sac. A dead fetus of 2.1 kg of term maturity was present in the amniotic sac. The placenta was attached right around the left fallopian tube (Fig. 1). The left ovary was also embedded in the placenta. The left tube was



**Fig. 1:** The placenta is attached to the left fallopian tube



**Fig. 2:** Left-sided adnexectomy is being done

hypertrophied. The right tube was short and distorted. Right-sided fimbriectomy with left-sided adnexectomy was done removing the placenta along with adnexa (Fig. 2). Two units of blood were transfused.

Postoperative period was uneventful. Autopsy of the fetus revealed no anomalies.

## DISCUSSION

Early abdominal pregnancy is self-limited by hemorrhage from trophoblastic invasion with complete abortion of gestational sac that leaves a discrete crater. Advanced abdominal pregnancy survives the hemorrhage of trophoblastic invasion and partial tubal abortion and implants secondarily in the first trimester on adjacent structures. It may progress to term if not diagnosed or interrupted by abruption placentae.<sup>3</sup> High index of suspicion may reduce the diagnostic error.<sup>4</sup>

Sonographic diagnosis of abdominal pregnancy is missed in half of the cases.<sup>1</sup> It has been misdiagnosed as placenta

praevia and abruption placentae.<sup>5-7</sup> The hypertrophied left tube must have been mistaken for the cervix on ultrasonography in this case. In a series studied, six out of 10 cases were diagnosed preoperatively.<sup>8</sup> Pain abdomen with abnormal fetal lie and FHS heard in the epigastrium, lack of cervical changes or a displaced cervix should lead to suspicion of abdominal pregnancy.<sup>9</sup> Congenital malformations in the fetus range from 20 to 40%.<sup>10</sup> In our case, no anomaly was noted.

Following basic principles of ultrasonography should minimize the error in diagnosis. These principles are as follows:

1. Confirm the presence of an intrauterine pregnancy.
2. If a gestational sac with a yolk sac and a pulsating embryo is visualized inside the adenexa, it is diagnostic of ectopic pregnancy.
3. If a gestational sac is not visualized inside the adenexa but the suspicion is high, look for other non-specific findings like an adenexal mass, free fluid in the Pouch of Douglas, adenexa and sometimes in the upper abdomen especially near the kidneys.
4. The other nonspecific findings on a color Doppler are a tubal vascular ring and identification no adenexal peritrophoblastic low-impedance flow.
5. Corpus luteal flow is identified in one or both the ovaries.

## CONCLUSION

High index of suspicion may reduce the diagnostic error.

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