

CASE REPORT

Secondary Abdominal Pregnancy: A Rare Presentation

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ABSTRACT

Background: Abdominal pregnancy has been defined as an implantation in the peritoneal cavity, exclusive of tubal, ovarian or intraligamentary pregnancy which further classified in primary and secondary abdominal pregnancy. Abdominal pregnancy is a rare event but it represents a grave risk to the health of the pregnant woman.

Case: A 32 years old multigravida presented at 16 weeks of pregnancy with complaints of pain in right iliac fossa since 4 days. Vaginal examination revealed a 12 weeks size uterus with an right adnexal mass. Sonography showed intrauterine placentation with dead fetus lying outside the uterus in the right fornix. On laparotomy, diagnosis of secondary abdominal pregnancy made and managed accordingly.

Conclusion: A high suspicion of abdominal pregnancy is to be kept in obstetrician mind because of its various presentation. Early diagnosis and management is required in this life-threatening condition. A combine approach of clinical as well as diagnostic technique is indicated.

Keywords: Abdominal pregnancy, Ectopic pregnancy, Maternal Mortality, Secondary abdominal pregnancy.

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INTRODUCTION

Abdominal pregnancy is a rare obstetric complication with high maternal mortality and even higher perinatal mortality. It is defined as an implantation of the embryo in the peritoneal cavity, exclusive of tubal, ovarian or intraligamentary pregnancy.¹ It can be primary or secondary with the latter being the most common type. Primary peritoneal implantation is very rare. Studdiford established three criteria for diagnosing primary

peritoneal pregnancies: (1) normal bilateral fallopian tubes and ovaries, (2) the absence of uteroperitoneal fistula and (3) a pregnancy related exclusively to the peritoneal surface and early enough to eliminate the possibility of secondary implantation following a primary nidation in the tube.² Secondary abdominal pregnancy is a condition where the embryo or fetus continues to grow in the abdominal cavity after its expulsion from the fallopian tube or other seat of its primary development. Secondary abdominal pregnancy almost always follows early rupture of a tubal ectopic pregnancy into the peritoneal cavity with the incidence being 1 in 10,000 live births.¹ Advanced abdominal pregnancy is rare and accounts for 1 in 25,000 pregnancies.³ The maternal mortality rate is 0.5 to 8%, and perinatal mortality ranges between 40 and 95%.²

Risk factors for abdominal pregnancy are the same as for ectopic pregnancy and, when it is recognized, immediate laparotomy with removal of the fetus is usually recommended. As it is a life-threatening condition, expectant management carries a risk of sudden life-threatening intra-abdominal bleeding and a generally poor fetal prognosis.⁴ We would be discussing a very rare and interesting presentation of abdominal pregnancy.

CASE REPORT

A 32 years old female presented at 16 weeks pregnancy with complaints of persistent pain in right iliac fossa since 4 days. Patient gave history of intake of abortifacient (tab Misoprostol 800 mg) 2 days back. She had two live issues with last child birth 4 years back and history of dilation and curettage (D&C) done 6 months back at 3 months of gestation in view of incomplete abortion. On admission, her systemic examination was within normal limits. On abdominal examination, uterus was corresponding to 12 weeks size. A mass of size 4 × 3 cm was palpable in right iliac fossa. It was a firm, tender, irregular mass with restricted mobility. Vaginal examination revealed 12 weeks size uterus with a tender palpable mass in the right fornix in continuity with uterus. A suspicion of appendicitis or possibility of heterotropic/ectopic pregnancy was raised. On sonography, showed intrauterine placentation with a dead fetus 12 weeks size lying outside the uterus in the right fornix (Fig. 1). With provisional diagnosis of uteroabdominal pregnancy, she was taken up for laparotomy. At surgery, uterus was bulky about 10 weeks size with a rent of 2 cm in the lower right lateral wall of uterus. An adherent pseudosac with dead fetus was seen in continuation with uterine wall and

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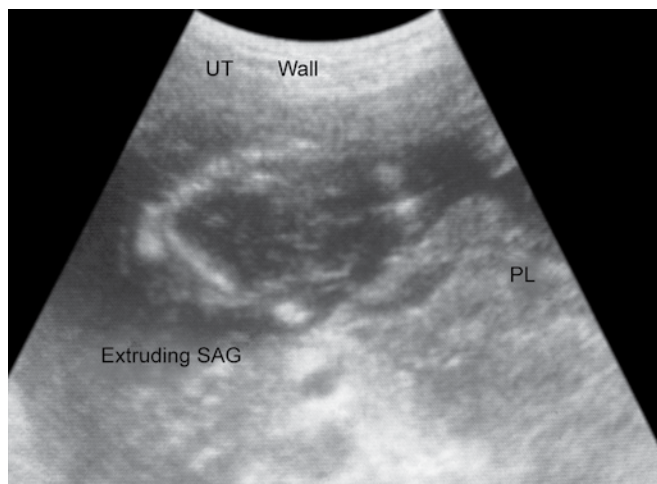


Fig. 1: Ultrasound showing pseudosac in the abdominal cavity with fetus inside and placenta (PL) in uterine cavity



Fig. 2: Pseudosac adherent to the lateral wall of the uterine cavity extruding out from the uterine rent

laterally attached to right pelvic wall (Fig. 2). Fetus was removed along with placenta from the perforated site of the uterus manually. The uterine rent was stitched and bilateral tubal ligation was done. Fetus in sac and placenta sent for histopathological examination. Postoperative period was uneventful.

DISCUSSION

Abdominal pregnancy is a rare obstetric complication with high maternal and perinatal mortality. Presentation of patients varies in form of spotting or irregular bleeding along with abdominal pain, nausea, vomiting, flatulence, constipation, diarrhea and abdominal pain. Small fetal parts may be palpated through the vaginal fornices or identified clearly outside the uterus. There may be delay in diagnosis because of varied atypical presentation. Diagnosis of advanced abdominal pregnancy requires a high index of suspicion. History and physical examination are often inconclusive. In spite of considerable improvement in technical abilities, absolute diagnosis by ultrasound is missed in half of the cases.⁵ A careful examination of uterine contour is helpful in early diagnosis. Magnetic resonance imaging (MRI) and computed tomography (CT) are both excellent diagnostic tools to diagnose secondary abdominal pregnancy as in about 50% of diagnoses are missed on ultrasound.⁵

Maternal deaths associated with abdominal pregnancy result from hemorrhage after inadvertent dislodgment of the placenta.

Early rupture of tubal ectopic pregnancy is the usual antecedent of a secondary abdominal pregnancy as reported by Shanbhag et al.⁶ Whereas advance secondary abdominal pregnancy have been reported by Desai et al⁷ and also till term by Farhet et al.⁸

Our case as discussed above is a very rare presentation of uteroabdominal pregnancy in which the probable pathogenesis is the presence of a rent which might have

existed at time of D&C done 6 months back. Through this rent, the fetus might have migrated to settle in peritoneal cavity as secondary abdominal pregnancy and grown to 12 weeks size with placenta. Similar case has been reported by Turbid et al.⁹

CONCLUSION

The presentation of a pregnant woman with an unusual clinical picture, especially with persistent or recurrent abdominal pain in association with painful fetal movements or intrauterine fetal death, should alert the obstetrician to the possibility of abdominal pregnancy. Expertly performed and interpreted ultrasonography may be the definitive diagnostic technique. It is imperative to consider this diagnosis in the case of such patients and, once discovered, to initiate prompt treatment.

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