# Full-Term Live Secondary Abdominal Pregnancy: A Rare Case Report

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## Introduction

In ectopic pregnancy, an extra-uterine abdominal pregnancy is a very rare form where implantation occurs within the peritoneal cavity excluding ovary, fallopian tube and broad ligament. It is estimated to occur in 1 out of 10,000 to 30,000 pregnancies.[1,2] Despite the use of routine antenatal ultrasound, its diagnosis is frequently missed.[3] It is extremely important to detect an extrauterine abdominal pregnancy because of the associated maternal mortality which is higher than ectopic pregnancy and intrauterine pregnancy. The factors that may influence the possibility of fetal survival are believed to be the site of implantation and availability of vascular supply. Full term abdominal pregnancy carries a risk of hemorrhage, disseminated intravascular coagulation, bowel obstruction and fistula formation. New born survival is also affected and there is increased perinatal mortality.

## Case Report

At our tertiary care hospital, a 22 year old patient was admitted to emergency room with complaints of 9-months amenorrhea and pain abdomen since morning. Patient was referred from primary health center and was a primigravida with transverse lie.

Her general condition on examination was good. Her pulse was 92 beats per min, BP—156/100 mm of Hg, patient did not know her LMP, and her menstrual history was not significant. She had past history of vague dull pain abdomen. On per abdomen examination uterine height was 32 weeks, lie was transverse and fetal heart rate was regular (136 beats per minute). On per vaginal examination cervix was 1.5 cm dilated, uneffaced, posterior in position, presenting part could not made out, pelvis was adequate. All the blood and urine investigations were within normal limit. Her last USG showed single live fetus of 35 weeks, in transverse lie with anencephaly, posterior placenta and adequate liquor.

Decision of emergency LSCS was taken due to transverse lie , blood was sent for grouping and cross-matching before the patient was taken to operation theater with written and informed consent. Patient was given spinal anesthesia, and self-retaining catheter was inserted. After opening the abdomen, amniotic sac was seen protruding in peritoneal cavity. Membrane was ruptured and baby female child of 2.7 kg was delivered as breech and handed over to pediatrician. There was profuse hemorrhage just after delivery of baby.

On exploration, placenta was found adherent to omentum and intestine. Fortunately, senior gynecologist and senior surgeon were present and they immediately joined the case. Demand of blood products was sent to blood bank. Placenta was separated from omentum and intestine as much as possible by surgeon and hemostasis achieved by application of multiple hemostatic sutures. Pelvis was

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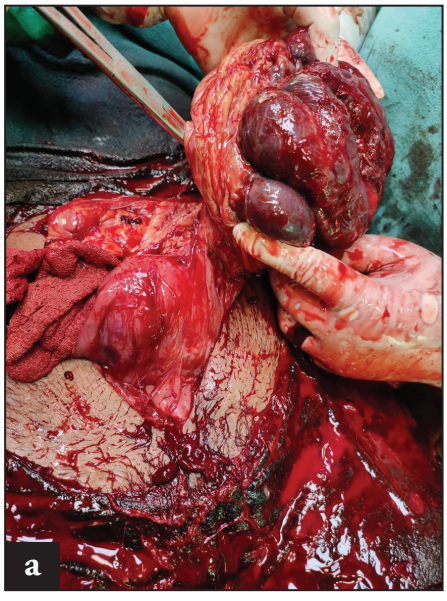



Pictures a and b showing placenta adhered to the omentum and intestines


Picture c showing a healthy female baby of 2.7 kg after caesarean.

explored, uterus was 6–8 weeks size and intact, and placenta was originating from the left-sided cornua. Right side tube and both ovaries were healthy. So secondary abdominal pregnancy was diagnosed. Placenta was removed after ligating the cornual stump and left sided salpingectomy was performed. Intra-operative 1 unit packed cell was transfused. Drain was inserted and abdomen was closed. Post-operatively 1 unit packed cell was transfused. Patient withstood the procedure well. Patient and healthy baby were discharged at day 8 postoperatively.

## Discussion

Beyond second trimester an extra-uterine abdominal pregnancy with a viable fetus is an extremely rare condition. The two types of extra-uterine abdominal pregnancy are: Primary abdominal pregnancy which refers to pregnancy where implantation of the fertilized ovum occurs directly in the abdominal cavity and the fallopian tubes and ovaries are intact where as secondary abdominal pregnancy occurs following an extra-uterine tubal pregnancy that ruptures or aborts and gets re-implanted within the abdomen.

In extra-uterine abdominal pregnancy patients typically complaints of persistent abdominal and/or gastrointestinal symptoms. Diagnosis of this condition is frequently missed, with only a few cases are diagnosed during the antenatal period. In our case, diagnosis was missed and misinterpreted as intrauterine pregnancy. Ultrasonography remains the main method for the diagnosis of extra-uterine pregnancy. It usually shows no uterine wall surrounding the fetus, fetal parts that are very close to the abdominal wall, abnormal lie and no or decreased amniotic fluid between the placenta and the fetus . Magnetic resonance imaging and serum a-fetoprotein have been used to diagnose abdominal pregnancy.[4,5] These tests were not performed in our patient as the diagnosis was not suspected.

Typical deformities have been observed in the extra-uterine abdominal pregnancy babies including limb defects, facial and cranial asymmetry, joint abnormalities and central nervous malformation. In this case it was seen that the baby was protected by the surrounding amniotic fluid and sac which could explain the absence of deformities in the baby and the massive bleeding that occurred from detached part of placenta was due to the adherence of the placenta to the abdominal viscera which, unlike the uterus, does not contract.

It has been observed that, it may be preferable to leave the placenta in place and allow its natural regression unless the placenta can be easily tied off or removed. There was significant bleeding from some detached portions of the placenta that prompted removal of these portions to secure hemostasis in this case .Maternal deaths associated with abdominal pregnancy result from hemorrhage after inadvertent dislodgment of the placenta. It is recommended to leave the placenta in

situ and follow-up with USG and human chorionic gonadotropin levels.

In abdominal pregnancy it is very rare to have a resultant healthy newborn. 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 al[7] and also till term by Farhet et al.[8]

In advanced pregnancy diagnosis of the condition can be difficult. The routine means of diagnosis are high level of suspicion, careful clinical and ultrasound examinations though CT scan and MRI can be useful. Bleeding is the single most important life threatening complication for the mother while fetal malformation is one of the numerous challenges that can confront the newborn.

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