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ABDOMINAL PREGNANCY: A CASE REPORT

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Abstract
This is a report of a case of abdominal pregnancy (a rare condition). Lack of antenatal care resulted in late presentation. Persistent abdominal pain, weight loss and pallor were the main clinical features. Presence of this triad in pregnancy should raise the suspicion of abdominal pregnancy.

Key words: Abdominal pregnancy

Introduction

About 2% of all pregnancies are ectopic and more than 95% of ectopic gestations occur within the Fallopian tubes. [1] Abdominal pregnancy, where implantation occurs within the peritoneal cavity is much more uncommon and accounts for 1 - 4%[2] of all ectopic pregnancies. Its incidence varies from place to place but is more common in developing countries. [3, 4] The worldwide incidence ranges between 1 in 33,000 and 1 in 10,200 deliveries. [2, 5, 6]

Diagnosis of abdominal pregnancy is difficult and often missed. [1, 7] High index of suspicion is therefore required in making the diagnosis. [8] Clinical features such as persistent abdominal pain, painful foetal movements, weight loss, abnormal presentations, uneffaced and displaced cervix, vaginal bleeding and palpation of an abdomino-pelvic mass distinct from the uterus should raise the suspicion. [2,9,10]

Abdominal pregnancy poses a grave risk to both the mother and foetus particularly due to trophoblastic invasion of surrounding structures and placental haemorrhage. [1, 11] Maternal and perinatal mortality rates of 0.5 - 18% and 40 - 95% respectively have been reported[1]. The management of this rare condition in is highlighted.

Case report

A 25-year unbooked gravida 2, para1^{+0}, none alive, presented in the gynaecological emergency unit of our hospital on 4th August 2002 with 10 months history of amenorrhoea and 5 months complaint of abdominal swelling, abdominal discomfort and weight loss. She was a house wife and had no formal education. Her last confinement was 10 years prior to presentation. It was complicated by prolonged obstructed labour and delivery of a macerated male still birth at home. Since then, she had been unable to conceive until 10 months prior to presentation. She was neither investigated nor had any treatment before the conception. From the 5th month of her amenorrhoea she started experiencing undue abdominal swelling associated with mild to moderate abdominal discomfort. She was also losing weight. She had no menstrual problems before the pregnancy.

Physical examination showed wasting and mild pallor. Pulse was 84 beats per minute and blood pressure 130/80 mmHg. The chest and the heart sounds were normal. Abdominal examination revealed distended and tensed abdomen with a mass of about 32 weeks gestational size. There was mild tenderness over the mass. The foetal parts were difficult to palpate because of the tensed abdomen. The foetal heart sound was not heard with sonicaid and there was no demonstrable ascites. Vaginal examination showed a firm and normal cervix with closed os. The uterus felt separate from the abdominal mass but its actual size was difficult to ascertain because of the tense abdomen.

Abdomino-pelvic ultrasound scan revealed slightly bulky uterus with empty endometrial cavity, extra-uterine singleton foetus with no cardiac activity, collapsed foetal skull and femoral length equivalent to 30 weeks gestation. Packed cell volume was 27%. Anaemia was corrected by blood transfusion. At laparotomy, the findings were; macerated male foetus lying in the abdominal cavity above the omentum (which obliterated the abdominal and pelvic organs), necrotic placenta that was implanted on the anterior abdominal wall and omentum, minimal haemoperitoneum, slightly enlarged uterus, grossly normal ovaries and normal right fallopian tube; the distal one-third of the left fallopian tube was buried in adhesion posteriorly. The placenta was removed without difficulty. The estimated blood loss was 800ml and two units of blood was transfused intra-operatively. Post-operative recovery was uneventful.

Discussion

Abdominal pregnancy is a rare obstetric complication with high maternal and even higher perinatal mortality. [1] It could be primary or secondary to implantation of a primary tubal pregnancy in the peritoneal cavity. The latter is the commonest type. [12] The incidence of abdominal pregnancy appears to be increasing in both developed and developing countries. In the former, increasing use of assisted reproduction with embryo transfer has been associated with increasing number of heterotopic pregnancies. [14 - 16] In developing countries, the high incidence has been reported to be due to increased risk of pelvic infections, limited diagnostic facilities for early detections of tubal pregnancies before secondary implantation in the peritoneal cavity and poor utilisation of medical care by pregnant women. [4, 17, 18]

Diagnosis of abdominal pregnancy is difficult and a high index of suspicion is important in recognising the condition. [6, 8] Persistent abdominal pain as in this report, is the commonest symptom. [9, 10] Other features include weight loss, vaginal bleeding and uneffaced cervix. These features, supported by ultrasonography made the diagnosis relatively easy in this patient.

When abdominal pregnancy is diagnosed, the widely accepted treatment is immediate laparotomy, for termination of pregnancy because of risk of maternal mortality and congenital abnormalities. [1,11] However, there has been debate regarding the use of a more conservative approach if the pregnancy is discovered after 24 weeks of gestation and the foetus is alive. [19] This approach should only be undertaken if the patient can be kept under strict observation, preferably in hospital. [7, 10]

One of the challenging problems during laparotomy for abdominal pregnancy is risk of massive haemorrhage when attempts are made to remove the placenta. [5] It is advised that except the entire blood supply of the placenta can be secured with minimal risk to the patient, the placenta is best left in-situ. [1, 7] If left in-situ, there is the need to follow-up the patient with serial β-human chorionic gonadotopin levels and sonograms (preferably colour Doppler) for placental involution. [20] Use of methotrexate to hasten placental involution and resorption has been reported. However, it may lead to accelerated placental destruction with accumulation of necrotic tissue and ultimately infection and abscess formation. [1] Removal of the placenta was not difficult in this report as it was already necrotic.

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