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Case Report

## A case report on advanced undiagnosed secondary abdominal pregnancy

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### ABSTRACT

Abdominal pregnancy is a rare form of ectopic pregnancy that involves implantation within the peritoneal cavity, exclusive of fallopian tubes, ovaries, broad ligament and cervix. Secondary abdominal pregnancy results from implantation of blastocyst into peritoneal cavity that was originally located elsewhere. It is associated with high maternal and fetal morbidity and mortality. Here, we have discussed about a 32 year old second gravida para one post caesarean section (last CS 2 years back) at 24+ weeks of gestation with rupture uterus with advanced secondary abdominal pregnancy with intrauterine death. Exploratory laparotomy with repair of rupture uterus with bilateral tubectomy was done.

**Keywords:** Secondary abdominal pregnancy, Rupture uterus, Ectopic pregnancy

### INTRODUCTION

Abdominal pregnancy is a rare form of ectopic pregnancy involving implantation of blastocyst within the peritoneal cavity, exclusive of fallopian tubes, ovaries, broad ligament and cervix. Primary abdominal pregnancy involves implantation of blastocyst in the abdominal cavity whereas secondary abdominal pregnancy involves implantation of blastocyst in abdominal cavity that was previously located elsewhere.

Early recognition and treatment of abdominal pregnancy may improve outcomes. However, it is often a late diagnosis. It is associated with high maternal and fetal morbidity and mortality, for example, maternal haemorrhage, bowel obstruction, fetal malformation, postpartum sepsis.

The incidence of abdominal pregnancy ranges between one per 10,000 to 30,000 live births or 1 percent of all

ectopic pregnancies.<sup>1</sup> The incidence of secondary abdominal pregnancy is higher than the primary one.<sup>2,3</sup>

Here, we have discussed about a 32 years old second gravida para one post caesarean section female at 24+ weeks of gestation with rupture uterus with advanced secondary abdominal pregnancy with intrauterine death.

### CASE REPORT

A 32 years old unbooked second gravida para one post caesarean section (last CS 2 years back) was referred from Silapathar Model Hospital, Silapathar, district Dhemaji, Assam on 21 January 2023 at 4 pm as a case of gravida two para one at 24 weeks of gestation with post C/S with rupture uterus with IUFD, with referral BP-128/80 mm of Hg and PR-137 min. The patient had no previous antenatal check-ups. She was received in labour room of Assam Medical College and Hospital at 5:45 pm with chief complaint of pain abdomen since last 2 days, with receiving BP-110/80 mm of Hg, PR-120 /min. On per abdominal examination, there was diffuse abdominal

tenderness and guarding and uterine contour could not be elicited. On per vaginal examination, cervix was long, os was closed and there was no bleeding. No blood investigations were available. Her ultrasonography report was suggestive of uterine scar rupture with abdominal pregnancy of 24 weeks 1 day with fetal demise with a wall defect of size 2.36 cm in lower uterine segment. After taking consent and explaining the involved risks, she was prepared for emergency exploratory laparotomy under general anaesthesia with 2 units of blood in hand. Even after giving general anaesthesia, uterine contour could not be elicited and fetal parts were easily palpable on per abdominal examination.

After incising the skin, subcutaneous tissue and rectus sheath vertically (previous CS incision was vertical), rectus muscles were separated. The peritoneum could not be identified properly and seemed to be thickened. On incising the peritoneum, amniotic sac contents (amniotic fluid, placenta and a macerated dead baby) were encountered. Following the delivery of dead macerated baby, placenta was found to be attached to anterior surface of uterus and overlying peritoneum and surrounding omentum and bowel and dome of bladder. Placenta could be easily separated and there was no active bleeding as the pregnancy was not viable. Few retroplacental clots were present. Bladder was pushed down and uterine rent was repaired. There was minimal bleeding from placental detachment sites which was secured. Bilateral tubectomy was done. 2 units of blood was transfused intraoperatively and one unit was transfused postoperatively.



**Figure 1: Amniotic sac wall in peritoneal cavity (lifted by surgeon's hand).**

Postoperatively, she was given higher antibiotics. The postoperative period was uneventful and she was discharged on postoperative day 8.

## DISCUSSION

Advanced abdominal pregnancy is extremely rare. Patients may be asymptomatic, may present with abdominal pain,

painful fetal movements, vaginal bleeding or life-threatening intraabdominal haemorrhage.

In this case, it was obvious that the abdominal implantation was secondary to undiagnosed uterine rupture.

Clinical diagnosis can be difficult and even ultrasound can be misleading, especially in later stages. MRI and CT scan are helpful in later stages.<sup>4</sup> In low resource settings, high index of suspicion helped in accurate diagnosis and timely intervention. Definitive diagnosis was made on surgical exploration.

Amniotomy of the gestational sac was followed by delivery of fetus and ligation of umbilical cord. Placental management may involve removal of placenta at the time of surgery, leaving the placenta in situ, postoperative methotrexate, selective embolization of placental bed. The decision was individualized depending upon site of placental location, adherence to surrounding structures and perceived risk of haemorrhage.

## CONCLUSION

Abdominal pregnancy is rare phenomenon associated with significant maternal morbidity and mortality. Clinical and radiological parameters can be misleading in many instances. High level of suspicion, careful clinical examination and timely intervention are the deciding factors for successful management.

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