

Accidental Finding of Early Secondary Abdominal Pregnancy

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Abstract

Abdominal pregnancy is extremely rare and is generally missed during antenatal care. It is a form of ectopic pregnancy where the embryo or fetus is growing in abdomen, outside the uterus; excluding fallopian tube, ovary and broad ligament. As most of the patients usually present with non-specific complaints, diagnosing this condition becomes challenging. Even in our case, diagnosis was made accidentally. Thus, this condition should be meticulously sought for, diagnosed and managed well in time.

Keywords: Abdominal Pregnancy; Ectopic Abdominal Pregnancy; Ectopic Pregnancy; Incidental Finding.

Introduction

Abdominal pregnancy has been defined as implantation in peritoneal cavity; exclusive of tubal, ovarian or intra-ligamentary pregnancy [1]. It can be primary or secondary; latter being more common. Secondary abdominal pregnancy is a condition where the embryo or foetus continues to grow in abdominal cavity, after its expulsion from fallopian tube or other sites of its primary development.

It is a rare obstetric complication with high maternal mortality rate and even higher perinatal mortality rate. Its incidence is 1 in 10,000 live births. Patients usually present with non-specific complaints like abdominal pain or vaginal bleeding during pregnancy. Mortality risk in abdominal pregnancy is 7.7 times that of tubal pregnancy and 90 times that of intrauterine pregnancy. Maternal morbidity generally results from infection, bleeding, pulmonary embolism, disseminated intravascular coagulation [2].

We report a referred case of a woman with non-specific complaints, diagnosed as a case of multiple fibroids with missed abortion and severe anaemia. The patient was diagnosed as a case of secondary abdominal pregnancy when posted for abdominal hysterectomy.

Case Report

A 30 year old Indian housewife, P₁L₁A₄, married since 12 years was referred to our out-patient department with complaints of mild pain in lower abdomen and irregular bleeding per vaginum since 2 months.

She had visited a private hospital 1 month back and was diagnosed as a case of 'Bulky uterus with multiple fibroids with missed abortion of ~ 6 weeks with severe anaemia (Hb- 6 gm%)'. She had received 2 blood transfusions (Whole blood). Dilatation and Evacuation was done in view of missed abortion (HPE report was not available with discharge notes). With no symptomatic relief, patient was referred to our hospital with accompanying ultrasonography report suggestive of 'Bulky Uterus with Multiple Uterine Fibroids; the largest measuring 4 X 4 cms suggestive of posterior subserosal fibroid'.

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Menstrual H/o- HerLMP dated 2 months back. Since then, she had irregular per vaginum bleeding. Her LLMP was 3 months back. Since 3 years, she had irregular cycles with 5-7 days bleeding per vaginum, with 30-60 days cycle length with associated dysmenorrhoea. Her menstrual cycles were regular prior to this.

Obstetric H/o-P₁L₁A₄. Married since 12 years. She had a 10 years old male child, FTND, live and well. Later, patient had 2 spontaneous abortions at 3 months gestation; followed by missed abortion at 2 months gestation for which D & E was done 1 month back. She did not practice any method of contraception.

On bimanual examination- Uterus was bulky ~10 week size with boggy feeling in POD (?Subserosal Fibroid).

Laboratory investigation- Hb was 8gm%. DLC was within normal limit. Serological tests were non-reactive. UPT was Negative. USG Abdomen was within normal limit. USG Pelvis was suggestive of bulky uterus (10 x 7 x 7 cms) with multiple small (~2 cms) anterior and posterior fundal intramural hypoechoic lesions. One hypoechoic lesion of 5 X 5 cms was seen posteriorly with broad base suggestive of subserosal fibroid. Endometrial thickness was 5mm. Impression- Bulky uterus with multiple fibroids.

Patient was admitted for blood transfusion and further management. One unit of PCV was transfused. Decision for laparotomy was made. Abdominal Hysterectomy was planned in view of multiple fibroids with menorrhagia. Patient did not desire future fertility.

On laparotomy, bulky uterus of 10 week size was found. Bilateral tubes and ovaries appeared normal. On separating omental adhesions on posterior side to reach the pouch of Douglas (POD), an organised mass measuring 6 x 5 cms was found. It was partially adhered to omentum; but was separate from uterus. Further peritoneal and omental adhesiolysis in POD revealed a dead foetus ~10-12 week. No cord structure was seen. Organised mass along with fetal structure was removed in toto. Total abdominal hysterectomy was carried out. Post-operative period was uneventful.

Histopathology report-Adenomyosis of uterus with focus of intra-myometrial trophoblastic tissue. Intramural degenerated trophoblastic tissue in right cornua was reported. Uterine wall was intact. There was no evidence of utero-peritoneal fistula. Organised mass had connective tissue with few endometrial glands and degenerated chorionic villi was suggestive

of secondary abdominal pregnancy. Foetal skeleton of about 10-12 weeks was reported. Impression- Secondary Abdominal (omental) pregnancy (?Expelled from right fallopian tube with secondary implantation in omentum).



Picture 1: Specimen

Discussion

Primary abdominal pregnancy refers to pregnancy where implantation of the fertilized ovum occurs directly in abdominal cavity. In these cases, fallopian tubes and ovaries are intact. In contrast; secondary abdominal pregnancy occurs following extra-uterine tubal pregnancy, which ruptures and gets re-implanted within the abdomen. The latter accounts for most cases of advanced extra-uterine pregnancy. In these cases, there is evidence of tubal or ovarian damage [3].

On the basis of laparotomy, histopathological findings and Studdiford's criteria, our case was classified as Secondary Abdominal pregnancy.

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 [4]. As abdominal pregnancy at less than 20 week of gestation is considered early; our case can be regarded as Early Secondary Abdominal pregnancy [5].

The exact pathogenesis of abdominal pregnancy is not known; but most abdominal pregnancies may result from tubal or ovarian pregnancies; as abdominal and tubal ectopic pregnancies share similar etiological factors [2]. Although there may be great variability in symptoms; severe lower abdominal pain is one of the most consistent finding in these cases. In a study of 12 patients reported by Hallatt and Grove, vaginal bleeding occurred in 6 patients

[6]. In our case; patient presented with both, bleeding per vaginum and abdominal pain. In early pregnancy, placental tissue can be removed with less difficulty as it is smaller and less vascular. In our case, as fetal demise had occurred; the organised placental tissue was removed intact. Use of progesterone only pills, intrauterine devices, previous history of pelvic inflammatory disease, sexually transmitted disease and previous surgery increases the risk of ectopic pregnancy. In our case, none of these risk factors was present.

Ultrasonography is useful in early diagnosis of this condition. Since adnexa and uterine cavity can be better visualised on transvaginal ultrasonography, it is a better diagnostic modality than transabdominal ultrasonography [7]. In our case, uterine fibroid was suspected (in view of posterior hypoechoic lesion) and thus, pre-operative diagnosis was missed. For precisely diagnosing and planning surgical management of ectopic pregnancy, non-contrast MRI using T₂-weighted imaging is a sensitive, specific and accurate tool [8].

Conclusion

Ectopic pregnancy occasionally goes undiagnosed. Women in reproductive age with symptoms as described in our case should be evaluated with high index of suspicion. Complaints at presentation, clinical examination, blood and urine sampling along with findings on ultrasonography may not be adequate. Thorough investigation is mandatory. As secondary abdominal pregnancy is associated with

high morbidity and mortality; timely diagnoses and intervention is of paramount importance.

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