Case Report

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Advancedsecondary Abdominal Pregnancy till Term: A Case Report

Nitin Kulkarni[1], Richa Patel[2], Anamika Arun[2], Nilay Patel[2]

Author's Affiliation:
[1]Associate Professor [2]Junior Resident, Department of Obstetrics and Gynaecology, ACPM Medical College, Dhule-424001, Maharashtra, India.

Corresponding Author:
Nitin N. Kulkarni,
Associate Professor, Department of Obstetrics and Gynaecology, ACPM Medical College, Dhule-424001, Maharashtra, India.
E-mail: kulkarnink76@gmail.com

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Abstract

Introduction: Advanced abdominal pregnancy is a rare condition with high maternal & fetal morbidity as well as mortality. Inadequate placentation, unusual implantation &associated anomalies increase maternal &fetal morbidity and mortality. Diagnosis & management of advance abdominal pregnancy is always a challenge for obstetricians. *Aims & Objectives:* Management of rare case of advanced secondary abdominal pregnancy. *Material & Methods:* A 20yr young second gravida with full term gestation with history of previous L.S.C.S. with transverse lie & low lying placenta refered to our institute for emergency LSCS. Her last USG at 34wks showing single live intrauterine fetus in transverse lie with placenta previa. We avoided per vaginal examination in v/o central placenta previa. Decision of emergency L.S.C.S. was taken. After opening abdomen we got many surprises, after all obstacles we came out with successful outcome. Happily closed the abdomen with expression of victory. *Results:* With skillful and patient handling we were able to manage such a rare case with successful outcome in terms of mother as well as fetus even with complete removal of placenta. *Conclusion*: Advanced secondary abdominal pregnancy are rarely diagnosed clinically. Use of timely ultra sonography, intra-operative recognition, surgical skill, ready access to blood products, patiently taking decision about status of placenta are the cornerstone of successful management. Dreadful surprises can change in a remarkable unforgettable victory.

Keywords: Advanced Abdominal Pregnancy(AAP); Secondary Abdominal Pregnancy.

Introduction

Advanced abdominal pregnancy is a rare condition with high maternal & foetal morbidity as well as mortality. Inadequate placentation, unusual implantation & associated anomalies increases maternal & foetal morbidity and mortality [1,2]. Diagnosis & management of advance abdominal pregnancy is always a challenge for obstetricians [3].

AAP can be classified as being primary or secondary. Primary AAP occurs when fertilized ovum implants directly into peritoneal cavity. It is less common type. The secondary AAP occurs when fertilized ovum first implants in fallopian tube, uterus or cornua of uterus and thendue to tubal abortion/ rupture or cornual rupture it develops outside the uterine cavity [4,5].

Rupture tubal ectopic pregnancy account for majority of secondary abdominal pregnancy [6]. Intraoperative decision of placenta removal /careful handling of placenta is most important to reduce morbidity and mortality. Here we are reporting a case of secondary abdominal pregnancy with successful outcome in view of mother as well as fetus.

Case Presentation

A 20yrs young second gravida with full term gestation with history of previous L.S.C.S. refer to our institute for emergency L.S.C.S., in view of transverse lie & low lying placenta. She was complaining of abdominal painwhich was not associated with per vaginal discharge/ bleeding/ leaking.

On review of her antenatal records, she had episode of PV spotting & pain in abdomen at 12wks & 20 wks gestation for which she sought treatment from private practitioner at remote place. Her usg report coinciding with clinical finding in terms of gestational age & foetal wellbeing. All otherinvestigations were within normal limits. Her last USG at 34wks 6 days wasshowing single live intrauterine foetus in transverse lie with central placenta previa.

On admission her vitals were stable except pallor. Her abdominal examination was confirmatory of referral finding. We avoided pervaginal examination in v/o central placenta previa.

Decision of emergency L.S.C.S. was taken keeping two points of whole blood ready with cross match.

Under all aseptic precautions & spinal anesthesia caesarean section started by pfannenstielincision, on entering parietal peritoneum findings were like a lion roaring towards you. All torturous engorged vessels were lying below opened peritoneum.

After detail and patient observation, we found left sided round ligament which was only structure showing avascular area, we first thought of dextrorotation of uterus. Skillfully we tried to search right sided round ligament & then we got surprise of AAP.

Thick vascular amniotic sac noted. We entered in amniotic cavity somehow finding a avascular area & full term live baby delivered by breech. Umbilical cord clamped and cut baby handed over to pediatrician. After taking deep breath & remembering all our theoretical knowledge we gently handledplacenta, examined a normal size uterus & its adenexa, we found placenta was attached to left cornu & part of broad ligament. By god's grace we were able to remove complete placenta uneventfully.Abdominal cavity lavaged with normal saline after complete hemostasis.

Happily closed the abdomen with expression of victory.

The female baby of 2.5 kg with Apgar of 6, 8, 9 at 0, 5 and 10min respectively. Examination of the newborn wasunremarkable.

Postoperatively patient received 1 unit of whole blood, otherwise it was uneventful till discharge on 7th day.

Follow up USG on 10th day was within normal limits. Follow up at 6wks & 6months were satisfactory in view of both mother as well as foetus.

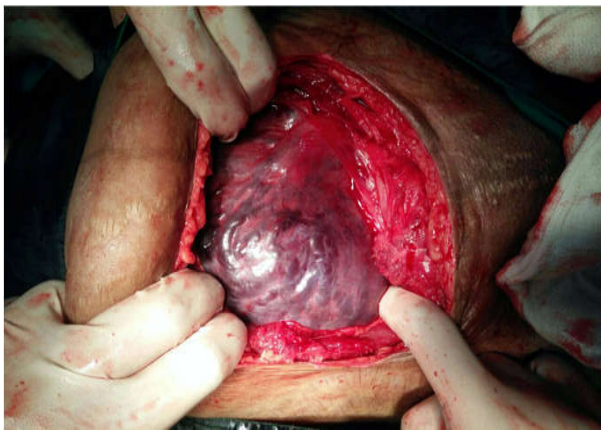

Fig. 1:

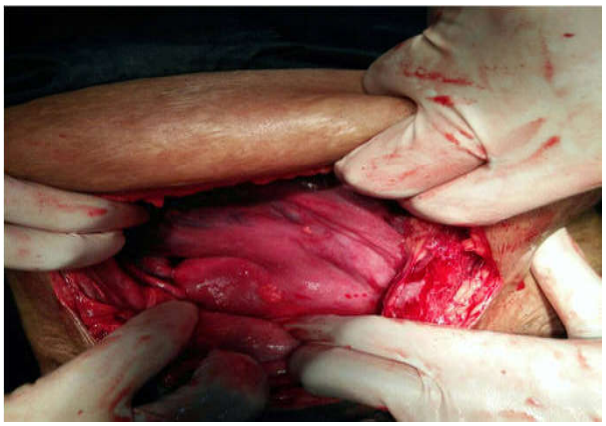

Fig. 2:

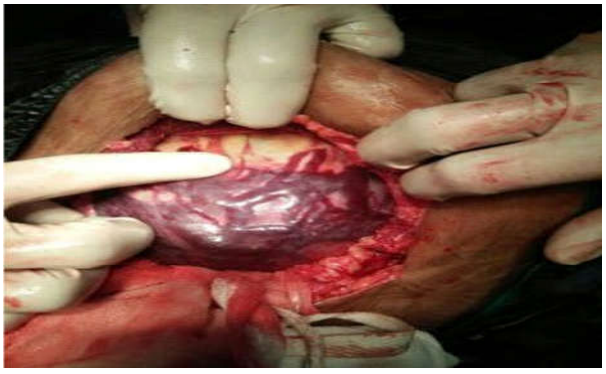

Fig. 3:

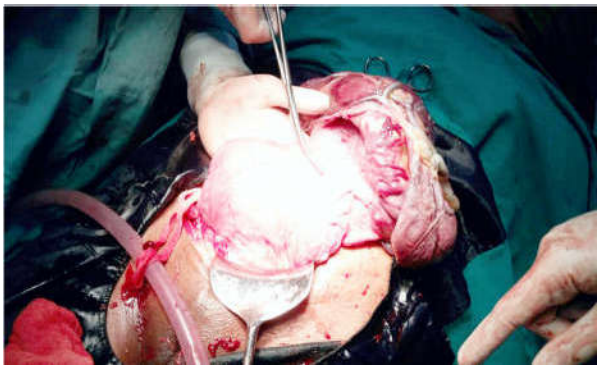

Fig. 4:

Discussion

After reevaluating all history, antenatal and radiological finding were giving clue towards diagnosis of AAP. Lower abdominal pain & PV spotting at 12 & 14 wks coincide with peak period of ruptured cornual ectopic which probably started growing towards broad ligament [7,8].

Malpresentation are mostly associated with either foetal or uterine anomalies [9]. Our patient had transverse lie which was an indication for L.S.C.S.

Removing placenta can result in catastrophic haemorrhage & damage to adjacent structure where as leaving it in situ is also a cause for morbidity [10].

In our case because of availability of blood after and feasibility of removal because of its attachment to limited area we made complete removal of placenta uneventfully.

Her follow up usg on 10 th post operative day was insignificant.

It is rare to have a live healthy baby in AAP. Being successfully managed even in terms of complete removal of placenta we are reporting this case.

Conclusion

Even advanced secondary abdominal pregnancy is rarely diagnosed clinically, with use of timely sonography, intraoperative recognition, surgical skill, ready access to blood products, patiently taking decision about status of placenta, one can successfully manage such cases. Dreadful surprises canchange in a remarkable unforgettable victory.

Consent

Written informed consent was obtained from the patient for publication of this case report and the accompanying images and video. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

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Competing Interests

The authors declare that they have no competing interests.

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