Abdominal Pregnancy at Term a Rare Case Report from Jinnah Post Graduate Medical Centre Karachi, Pakistan

Farah Hassan Khan, Tanzila Fahim, Nighat Ali Shah, Fahad Ali

ABSTRACT:
Abdominal pregnancy is an extreme rare situation and the quoted incidence is 1.4% of all ectopic pregnancies. The diagnosis and management is challenging and requires multidisciplinary input, if not managed in good hands can lead to serious consequences leading to maternal and neonatal mortality. We present a case of 32 years old abdominal pregnancy which presented to us at 31 weeks pregnancy with severe vomiting and mild abdominal pain. The site of pregnancy went unrecognized till 35 weeks pregnancy until she was operated in suspicion of placenta Previa. The patient recovered smoothly after surgery and went home in stable condition. Abdominal pregnancy is challenging to diagnose and manage. It requires not only clinical expertise but also strong radiological guidance to advice management. A rare presentation of persistent nausea and vomiting due to compression of underlying intestines may lead to consider the diagnosis of abdominal pregnancy in later gestation.

Keywords: Abdominal pregnancy, Ectopic pregnancy, Laparotomy.

INTRODUCTION:
Abdominal pregnancy is a rare type of ectopic pregnancy with presentation around 1%. It is more common in our part of the world due to poor socioeconomic conditions and more risk of infections in pelvis. The world wide incidence ranges between 1 in 33,000 and 1 in 10,200 deliveries. The presentation is mostly acute abdomen and is identified in early pregnancy. The early surgical intervention is the key to save maternal mortality.

Abdominal pregnancy at term with a healthy viable fetus is therefore an extremely rare condition and very few of such cases have been published during the last ten years. We present an extremely interesting case of abdominal pregnancy with varied presentation that resulted in a term live baby without deformities.

INTRODUCTION:
Abdominal pregnancy is a rare type of ectopic pregnancy with presentation around 1%. It is more common in our part of the world due to poor socioeconomic conditions and more risk of infections in pelvis. The world wide incidence ranges between 1 in 33,000 and 1 in 10,200 deliveries. The presentation is mostly acute abdomen and is identified in early pregnancy. The early surgical intervention is the key to save maternal mortality.

Abdominal pregnancy at term with a healthy viable fetus is therefore an extremely rare condition and very few of such cases have been published during the last ten years. We present an extremely interesting case of abdominal pregnancy with varied presentation that resulted in a term live baby without deformities.

CASE PRESENTATION:
A 28 years old female G3P2+0 was admitted in emergency room at Jinnah Post graduate medical Centre, ward 9B with severe dehydration and excessive nausea and vomiting at 32 weeks of pregnancy. She also has complaints of dull, intense abdominal pain and weight loss. She also complained of constipation. She belongs to a small village of Gwadar, Baluchistan and was a housewife with no formal education. She has 2 previous normal vaginal deliveries and last born was 6 years back. From the 3 rd. month of pregnancy she started to experience abdominal pain and vomiting which was managed conservatively by her local doctor. No early scan was available and according to her estimation she was 8 months pregnant. She was also not sure of her dates.

Physical examination showed wasting and cachexic look with moderate pallor. Pulse was 108 per minute with BP of 100/60 mm Hg. The Chest and heart sounds were normal. Abdominal examination showed distended abdomen with a height of fundus of 29 weeks. There was mild tenderness over the belly. The fetal parts were not appreciated on clinical examination. The fetal heart sounds were audible. Vaginal examination showed a normal cervix with closed Os slightly tilted towards right side.

We suspected intestinal obstruction in view of persistent vomitings and constipation. She was passed NG tube which drained 800 ml of stomach contents. Her Hemoglobin was 6 mg/dl so was corrected by blood transfusion. GS team cleared her from there side and she passed stool after 2 days. Her general condition improved after IV fluids, antibiotics and blood transfusion so she was planned for discharge after ultrasound.

Farah Hassan Khan (Corresponding Author)
Senior Instructor, Department of Obstetrics and Gynaecology Jinnah Post Graduate Medical Center, Ward 9B, Karachi Email: dr.farahfahad@gmail.com

Tanzila Fahim
RMO, Department of Obstetrics and Gynaecology Jinnah Post Graduate Medical Center, Ward 9B, Karachi Email: drtanzila@hotmail.com

Nighat Ali Shah
Head Department of Obstetrics and Gynaecology Jinnah Post Graduate Medical Center, Ward 9B, Karachi Email: nighat.shah@gmail.com

Fahad Ali
Visiting Faculty, Department of Obstetrics and Gynaecology Jinnah Post Graduate Medical Center, Ward 9B, Karachi Email: dr.fahadali.smc@gmail.com

Received: 07-12-2023
Accepted: 21-03-2024
1st Revision: 14-12-2023
Ultrasound findings showed an alive intrauterine fetus with breech presentation. The fetal parameters corresponding to 33 weeks. Scanty liquor. Placenta was anterior low lying covering the Os. Dilated, fluid filled, loaded bowel loops seen with sluggish peristalsis. Ultrasound abdomen done showed normal viscera with just prominent bowel loops.

She presented again after one week in OPD with same complains of abdominal pain and constipation. She was again admitted for conservative treatment. Baselines were repeated and ultrasound was done. This time ultrasound showed single alive fetus with breech presentation at 34 weeks pregnancy.AFI of 5.3 cm. Placenta posterior low lying completely covering the Os, loss of interface between bladder wall and myometrium, few vessels are seen running longitudinally and transversely suggestive of placenta Previa.

On view of persistent abdominal pain on /off she was planned for surgery at 35 weeks pregnancy after arrangement of blood and ICU. No suspicion of abdominal pregnancy was given sonographically or clinically. She was planned to be operated on the lines of placenta previa with suspected morbidly adherent placenta.

Operative findings showed on opening the cavity a large feeding vessel was visualized and placenta was found adherent to omentum. A vessel started to bleed so nick given after pushing peritoneum down. The baby was delivered with good apgars (shown in figure 4). Placenta was found adherent to omentum (as shown in figure 1). On exploring pelvic cavity uterus was found tilted towards right side and was normal in appearance corresponding to 14 weeks (as shown in figures 2). The left side of the tube was torn and some portion of placenta was attached to cornu (as shown in figure 3). The damaged tube was removed and whole of the pedicle was clamped, cut and ligated. GS team was involved which helped in removing all of the placenta with omentum. Bilateral tubal ligation was done and a drain was left in peritoneal cavity after extensive washing with normal saline.

She was transfused 4 pint PC and 4 FFps during surgery as estimated blood loss was 2.5 litres and was shifted to ICU for further monitoring. The Patient was kept on ventilator for 24 hours and was extubated and stable. She was discharged in stable state at 6th post-operative day.

Figure 2: 14 Weeks size uterus

Figure 3: Left tube torn and some portion of placenta was attached to cornu
REFERENCES: