Case Report

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

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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 suspection 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.

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INTRODUCTION:

Abdominal pregnancy is a rare type of ectopic pregnancy with presentation around 1 %.[1] It is more common in our part of the world due to poor socio economic conditions and more risk of infections in pelvis.[2] The world wide incidence ranges between 1 in 33,000 and 1 in 10,200 deliveries. [3] 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. [2,4] We present an extremely interesting case of abdominal pregnancy with varied presentation that resulted in a term live baby without deformities.

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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 complains 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.

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 suspection 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.

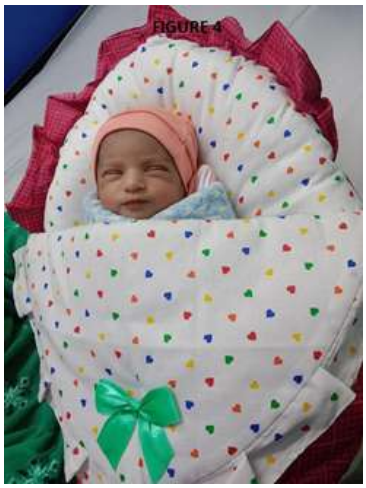
She was transfused 4 pint PC and 4 FFps during surgery as estimated blood loss was 2.5 litres and was shifted to ICU for further monitoring. The Patient was kept on ventilator for 24 hours and was extubated and stable. She was discharged in stable state at 6th post-operative day.

Figure 1: Placenta adherent to omentum

Figure 2: 14 Weeks size uterus

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

Figures 4: The baby with good apgars scores



Authors Contributions:
Farah Hassan Khan: Topic selection, study design, data collection, manuscript writing
Tanzila Fahim: Study design, manuscript writing proof reading
Nighat Ali Shah: Sample collection, study design, methodology
Fahad Ali: Sample collection, study design, methodology

REFERENCES:

1. Mamo A, Adkins K. Abdominal pregnancy: pathophysiology, diagnosis, and treatment. Journal of Gynecologic Surgery. 2022 Jun 1;38(3):193-6. DOI:https://doi.org/10.1089/ gyn. 2022. 0013
2. Hailu FG, Yihunie GT, Essa AA, Tsega WK. Advanced abdominal pregnancy, with live fetus and severe preeclampsia, case report. BMC pregnancy and childbirth. 2017 Dec;17:1-4.
3. Nwobodo EI. Abdominal pregnancy: a case report. Ann Afr Med. 2004;3(4):195-6.
4. Baffoe P, Fofie C, Gandau BN. Term abdominal pregnancy with healthy newborn: a case report. Ghana Medical Journal. 2011 Aug 23;45(2).Page 81-83.
5. Siati A, Berrada T, Kharbach A. Abdominal pregnancy with a healthy newborn: a new case. Pan African Medical Journal. 2019 Sep 16;34 (1). DOI:10.11604/pamj.2019.34.35.20169
6. Pednekar G, Dweep J, Surve S. Successful outcome in a near term Secondary Abdominal pregnancy presenting as Diagnostic Dilemma. IOSR Journal of Dental and Medical Sciences. 2013;8(6): 83-6.
7. Wu L, Jiang X, Ni J. Successful diagnosis and treatment of early splenic ectopic pregnancy: A case report. Medicine (Baltimore). 2018 Apr;97(17):e0466. doi: 10.1097/MD.0000000000010466. Erratum in: Medicine (Baltimore). 2018 Aug;97(34):e12141. PMID: 29703001; PMCID: PMC5944564.
8. Molinaro TA, Barnhart KT. Ectopic pregnancies in unusual locations. InSeminars in reproductive medicine 2007 Mar (Vol. 25, No. 02, pp. 123-130). Copyright© 2007 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA.
9. Dahab AA, Aburass R, Shawkat W, Babgi R, Essa O, Mujallid RH. Full-term extrauterine abdominal pregnancy: a case report. Journal of medical case reports. 2011 Dec;5:1-4.
10. Huang K, Song L, Wang L, Gao Z, Meng Y, Lu Y. Advanced abdominal pregnancy: an increasingly challenging clinical concern for obstetricians. International journal of clinical and experimental pathology. 2014;7(9):5461. PMID: 25337188
11. Kim MJ, Bae JY, Seong WJ, Lee YS. Sonographic diagnosis of a viable abdominal pregnancy with planned delivery after fetal lung maturation. Journal of Clinical Ultrasound. 2013 Nov;41(9):563-5. DOI: https://doi.org/10.1002/jcu.22010
12. Fessehaye A, Gashawbeza B, Daba M, Arusi M, Terefe T. Abdominal ectopic pregnancy complicated with a large bowel injury: a case report. J Med Case Rep. 2021;15(1):1–5. DOI:10.1186/s13256-021-02713-9