

TERM ABDOMINAL PREGNANCY MISDIAGNOSED AS ABRUPTIO PLACENTA.

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ABSTRACT:

A 37 year old multiparous woman at 37th week gestation presented with an undiagnosed abdominal pregnancy and acute abdomen following forceful reduction of an associated utero-vaginal prolapse.

She had an urgent laparotomy with delivery of a live female baby lying in the left broad ligament. The baby weighed 2.6kg with Apgar scores of 2 and 6 at first and fifth minutes respectively. The partially detached placenta was easily delivered complete with membranes. Haemostasis was secured by ligation and excision of the left adnexum (broad ligament with the pregnancy sac and uterine appendages). She was transfused with two units of whole blood.

This case highlights the importance of excluding pregnancy in any woman of reproductive age with undiagnosed abdominal mass and utero-vaginal prolapse before any manipulation. It also underscores the importance of ultrasound scan in early pregnancy by a competent sonologist.

INTRODUCTION:

Abdominal pregnancy is a very rare form of ectopic pregnancy and an important cause of perinatal and maternal morbidity and mortality^{1,2}. Even with recent technological advances in methods of diagnosis, it still poses a diagnostic and management dilemma. The case presented here is a typical example.

Abdominal pregnancy is associated with several complications including; massive haemorrhage (haemoperitoneum), acute abdomen, intestinal obstruction, sepsis and death³. However, a good aspect of abdominal pregnancy is that though a pathological condition, it gives a rare hope to the hysterectomised woman that she can carry a baby of her own without any need of surrogacy⁴.

We report a case of term abdominal pregnancy diagnosed at caesarean section for abruptio placenta with a live fetus. We also highlight the associated utero-vaginal prolapse as a complication of abdominal pregnancy.

CASE REPORT:

Mrs. I.A, a 37 year old petty trader presented to us at the 37th week of her 4th pregnancy as an emergency on 28th November 2003. She complained of severe abdominal pain of four days duration. The pain had been mild until 4 days prior to presentation when she had a forceful reduction of a mass protruding through her vagina by a general practitioner. This mass had been there since the 2nd trimester and reduced spontaneously until the time of the manipulation when it could not reduce spontaneously.

The abdominal pain was more on the left lower abdomen and there was associated scanty vaginal bleeding but no drainage of liquor. Two previous ultrasound studies she had at the 2nd and early 3rd trimester for abnormal lie reported normal fetus and normally located placenta. Her 3 previous pregnancies were uneventful and she had had normal deliveries in all.

Examination revealed a pregnant woman in painful distress, pale, afebrile and no pedal oedema. The pulse was 96 beats/minute, regular and full volume with a blood pressure of 120/80 mmHg. The cardio vascular and respiratory systems were normal. The abdomen was uniformly enlarged, very tender and tensed. The fundal height was 36 weeks, but the lie and presentation could not be determined due to the tenderness. The fetal heart rate with sonicaid was 156 beats/minute. There was no active vaginal bleeding.

A diagnosis of concealed abruptio placenta was made by a junior resident. This was confirmed at ultrasonography that also revealed a singleton live fetus at 37 weeks and 3 days gestation, cephalic presentation, longitudinal lie and biophysical profile of 6/10. The placenta was grade 3, posterior fundal; with retro-placental clot and the liquor volume was adequate. She was subsequently booked for emergency lower segment caesarean section, 2 units of whole blood were grouped and cross-matched and her packed cell volume was 0.28 l/l. Urinalysis showed protein 600mg/l, red blood cell (+) and granular cast (++) . Clotting time was 4 minutes. Resuscitation with intravenous fluids and analgesics was commenced.

The findings at laparotomy (a sub-umbilical midline incision was used) were massive haemoperitoneum and a pregnancy sac with

prominent vessels and a linear rupture. A transverse incision was made on the lower half of this sac and the amniotic sac punctured to deliver a female baby with Apgar score of 2 at one minute and 6 at five minutes that weighed 2.6kg. The placenta was easily delivered. At this point, the bulky 14 weeks size uterus was identified and the right appendages were normal see

Picture 1: Display of the Uterus and the Abdominal Pregnancy Sac in-situ



The base of the left adnexum involving the pregnancy sac, broad ligament and uterine appendages was clamped, excised, and ligated with chromic catgut No. 2 to ensure adequate haemostasis.

Picture 2: The Abdominal Pregnancy Sac after removal



The peritoneal cavity was cleaned with sterile mops and the abdomen closed in layers with appropriate sutures.

She was managed post-operatively with antibiotics (Ampiclox Ig six hourly and Gentamycin 80mg eight hourly), analgesics, intravenous fluids,

and haematinics. Her post operative recovery was uneventful and she was discharged home on 13th post operative day after removal of the skin sutures. The baby died within 24hours at the special care baby unit of the hospital. She was seen again at 6 weeks post natal visit and was normal.

DISCUSSION:

Abdominal pregnancy, a form of ectopic pregnancy may occur primarily or following abortion of a tubal pregnancy with subsequent implantation and development in the peritoneal cavity. The incidence ranges from 1 in 3000 -10,000 of all pregnancies or 1-2% of ectopic pregnancies^{1,2}. It has also been reported in a hysterectomised patient⁴.

It often poses a diagnostic dilemma especially when presenting late without proper previous evaluation as in our patient³. Pregnancy complications including persisting abdominal pain, vaginal spotting and abnormal lie are indicative and confirmation is usually by ultrasonography⁵.

Our patient presented late and though she had the above features, the ultrasound confirmation of abruptio placenta completely deceived us. Therefore, a high index of suspicion is necessary to clinch the diagnosis especially in late presentation as in our patient.

An unusual presentation in our patient is utero-vaginal prolapse, the reduction of which triggered the abdominal pain she presented with. The utero-vaginal prolapse would result from the increased intra-abdominal pressure, and the peculiar location of the abdominal pregnancy. We therefore recommend that intervention measures for utero-vaginal prolapse coexisting with abdominal mass should come after clear diagnosis has been made.

Management of abdominal pregnancy depends on the gestational age, clinical state of the patient, site of implantation of the placenta, state of the fetus and patients informed consent. In our patient, the diagnosis was made at caesarean section and the partially separated placenta was easily delivered complete with membranes. Other workers have reported cases where placenta is left in-situ for autolysis and managed conservatively with antibiotics. This is likely where the placenta is lying on a vital structure like major blood vessels or very adherent to its site⁶.

In conclusion, the patient carried this pregnancy to viability without any special care proving that extra-uterine pregnancy can be managed to viability.

Secondly, it has shown that abdominal pregnancy would predispose to utero-vaginal prolapse. Finally, an index of suspicion and ultrasound scan in early pregnancy by a competent sonologist will facilitate early and accurate diagnosis especially with a specialist care.

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