Case Report

Abdominal Pregnancy

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This is a report of a late, primary abdominal pregnancy presenting as an IUD in Gynae out patient department of Services Hospital, Lahore. Despite ultrasonography initially the diagnosis was missed, which is not an exception. After diagnosis abdominal delivery with placental retention was carried out followed by methotrexate therapy. A high index of suspicion is required to diagnose such rare cases specially when they have a wide range of presentations.

Key Words: Abdominal pregnancy, laparotomy, methotrexate therapy

With the rise in Pelvic Inflammatory Disease and IVF pregnancies the rate of ectopic pregnancy is also increasing. This still remains one of the major causes of maternal mortality and morbidity, especially due to late presentation and late diagnosis. Abdominal Pregnancy, being a rare form of ectopic, needs a high index of suspicion for early diagnosis.

Abdominal pregnancies may be due to direct implantation (primary) or after tubal abortion (secondary). Primary abdominal pregnancies of advanced gestational age are typical examples of late or missed diagnoses; even with the aid of good diagnostic modalities .It is associated with a high fetal mortality rate and a maternal mortality is variously quoted between 6 and 18 percent. Implantation of placenta on the abdominal viscera makes removal at the time of surgery difficult and dangerous. The case reported shows the variety of clinical presentation, possibilities of errors of diagnostic modalities and outcome of methotrexate management.

Case Report:

A thirty-six years old gravada six para five with previous one cesarean section, presented with a history of amenorrhoea of thirty weeks and loss of fetal movements since one day. She had not had any antenatal visits in this pregnancy. No previous ultrasound or any other tests were available. All her previous deliveries were carried out at home except one and she did not report any antenatal, intrapartum or postpartum complications. All her issues were alive and healthy She did not have any history of pelvic inflammatory disease or previous ectopic pregnancy. She was a non smoker.

The positive features on general examination were of obesity and hypertension (140/90). On abdominal examination the fundal height was felt vaguely to be about twenty-eight weeks however there was difficulty in properly palpating the uterus, which was thought to be because of her obesity. Fetal heart sounds could not be heard with Doppler. Vaginal examination was not carried out at that time. The patient was sent to radiology department for an ultrasound to confirm IUD. It showed an intrauterine pregnancy of twenty-six weeks with cephalic presentation, normal liquor, *absent* fetal heart sound and fundal placenta. Vaginal examination reveled an unaffected posteriorly placed cervix. The patient was counseled about the situation and management options and after her consent oral prostaglandin E1 was started for termination of pregnancy. However despite the patient's complains of intermittent abdominal pain contractions could not be palpated. Vaginal examination revealed a 3 cm long uneffaced cervix with a firm consistency. She was again sent for an ultrasound from a consultant. This report reveled an abdominal pregnancy of twenty seven $\pm$ two weeks with a parous sized uterus. She was informed about the error of diagnosis, counseled and apologized to, and the management plan was discussed. Intravenous antibiotics were started She was prepared for laparotomy.

A sub umbilical midline incision was given. On opening the abdomen the bag of membrane, which was immediately below the peritoneum, was identified and packs were inserted on the sides to minimize the spill. Membranes were ruptured and a dead baby boy was delivered. Cord was clamped and ligated with catgut no.1. Placenta was left in situ. Placenta was invading the omental and intestinal vessels. The cavity was sponged and cleaned. Her bilateral tubal ligation was carried out.
The baby weighed 1.5 kg and did not have any apparent congenital abnormality. The cord had normally placed three vessels. Baby showed signs of maceration.

Post operatively, apart from fluid management, antibiotics and analgesics patient was given Methotrexate 50mg in 500ml of saline. Consecutive BHCG showed a consistent fall and patient was discharged on 10^{th} postoperative day in a healthy state with advise for follow up after a week. She presented two weeks later with complaints of pain in abdomen and pus from wound for 2 – 3 days for which she had consulted a local GP. On examination there was mild induration and about 1 cm dehiscence of wound but no active pus even on pressing the wound. Per vaginal examination and ultra sound did not reveal any collection of fluid/pus. The patient was admitted, given anti-inflammatories and observed for three days. She remained healthy, practically pain free and her

wound showed signs of healing. She was allowed to go home with advise for follow up.

Discussion:

Ectopic pregnancy has seen a rise in the past decade. Abdominal pregnancy constitutes approximately 1% of the ectopic pregnancy. The quoted incidence of abdominal pregnancy is 1 in 3200[1] to 10,000[2]. In gynae unit 1 at Services hospital the incidence comes to be about 1 in 7000. Although cases have been reported of live births[3,4,5,6], abdominal pregnancy is associated with a high fetal mortality; about 70%[1]

Abdominal pregnancy can be primary or secondary. This seemed to be a case of primary pregnancy. A rare entity in itself, the case reported is a typical example of delayed diagnosis due to lack of antenatal care, low index of suspicion and failure of a single ultrasound to detect the true situation. In this case the patient's presentation with a history of amenorrhoea and normal fetal movements till a few days back, potentiated with the ultrasound report deviated the attention from the clinical suspicion. It is similar to the case report by Rice-T from Kansas City, U.S.A. who reported failure of diagnosis – even after multiple ultrasounds – of an advanced abdominal pregnancy[7].

A case report of hemothorax caused by diaphragmatic implantation of abdominal pregnancy[8], primary hepatic pregnancy[9], lithopedion[10,11], fecal fistula[12] etc shows the wide variation in presentation.

Fetuses in Abdominal Pregnancy have a higher incidence of congenital abnormalities. This particular baby was apparently normal.

Postoperative management may be conservative or with methotrexate. With methotrexate chances of placental necrosis are increased. One school of thought is against using methotrexate[13]. It may culminate in greater patient morbidity. Our patient however showed good recovery despite the necrosis and pus formation. Re injection of methotrexate was given following the guidelines of medical management of ectopic (tubal etc.) pregnancy (Current Management in Obstetrics and Gynecology—2000). However greater world wide experience is required to chart out the best management of the placenta left in situ.

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