

## Secondary Abdominal Pregnancy Following Tubal Abortion: A unique case

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### Abstract:

Secondary abdominal pregnancy is the gestation outside the uterus. It poses great clinical challenge to the clinician to treat and the diagnosis is tough to establish. This was case study of 30 years old primigravida presented with 8 months amenorrhea, bleeding per vaginum, pain abdomen, loss of fetal movements. There was failed induction of labor and secondary abdominal pregnancy diagnosed on review sonography. That was managed by exploratory laparotomy.

**Keywords:** Abdominal Pregnancy, Laparotomy, Failed Induction.

### Introduction:

India accounts for nearly one-fifth of the global burden of Abdominal pregnancy is perhaps both the rarest and the most serious type of extra uterine gestation<sup>1</sup>. The incidence of abdominal pregnancy is 1:10,000<sup>1</sup>. The incidence of advanced abdominal pregnancy is approximately 1 in 25000 births<sup>2</sup>. The overall mortality rate associated with abdominal pregnancy is 0.5 to 8.0 %<sup>3</sup>. Delay in diagnosis is mainly due to difficulties in clinical assessment caused by variance in presentations. Continuation of pregnancy is very rare without manifestation of hemoperitoneum.

### Case Report

A 30 years old primigravida with 8 months amenorrhea reported to tertiary care teaching hospital of Rajasthan on 14 Jan 2010 as a case of intrauterine death (IUD) with bleeding per vagina and pain abdomen for one day and loss of fetal movements for 8 to 10 days. Her LMP was 15 April 2009. She was married for 10 years and taking treatment for primary infertility. She was anemic but haemodynamically stable.

The abdominal examination showed 24 to 26 weeks sized uterus deviated more on right side and fetal heart sound was not localized. Uterus was not acting. On vaginal examination cervical os was closed and slight bleeding per os was present.

There was history of bleeding in early pregnancy at 6 to 8 weeks of gestation for which she was treated as threatened abortion at private hospital. Her outside previous ultrasonography records were showing progressively growing intrauterine pregnancy with severe oligohydramnios with transverse lie with retro placental hemorrhage right from 6 to 8 weeks of gestation. Routine blood investigations and coagulation profile were within normal limits. Since IUD was sonographically diagnosed so decision was taken for termination of pregnancy. Induction was done by 3 doses of dinoprostone (prostaglandin) gel, intravenous oxytocin and lastly ethacrydine instillation.

There was failed induction so review sonography was done which confirmed secondary abdominal pregnancy.

In view secondary abdominal pregnancy with anemia, laparotomy was decided. Two units of blood transfused preoperatively. Exploratory Laparotomy was carried out. After opening of abdominal cavity difficulties encountered due to adhesions of gut and omentum to parities, same separated and a dead fetus of about 24 weeks gestation (750 grams) was lying in abdominal cavity on right side lower abdomen on which gut and omentum were adherent. Fetus was removed en sac as shown in (Figure 1).

Figure 1: Dead fetus with placenta.



Amniotic fluid was absent. There were fetal compression deformities of limbs and face, anal verge was absent with ambiguous genitalia. There was a placental mass adherent to fundus of the uterus on which gut and left fallopian tube which was thickened and enlarged with grossly dilated ampullary portion was adherent. Placental mass removed after separating adhesions from surrounding structures and left sided salpingectomy was done. Adhesions were obliterating pelvic cavity only fundus of the uterus was visualized and there was no sign of uterine perforation.

Specimen saved for photography and for academic purposes after due consent. The post operative period was uneventful.

#### Discussion:

Abdominal pregnancy is a rare obstetric complication with high maternal and perinatal morbidity and mortality<sup>4</sup>. As early rupture of tubal ectopic pregnancy is the usual antecedent of a secondary abdominal pregnancy, a suggestive history can usually be obtained. If there is persistent fetal malpresentation and high fetal position. or failure of spontaneous onset of labor or failed induction for termination of pregnancy. One should review the diagnosis. About 50% of diagnosis are missed on ultrasound<sup>5</sup> but MRI and CT are both excellent diagnostic tools to diagnose secondary abdominal pregnancy<sup>6,7</sup>. In our case this case referred to us as a diagnosed IUD, when there was failed induction then only on review ultrasound diagnosis was made. Serious hemorrhage can occur because of inadvertent disruption of blood supply in the process of fetal removal. This is likely due to inadvertent disruption of placental blood supply as well as the difficult surgical challenges presented by extensive adhesion formation<sup>8</sup>.

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