Case Report

Abdominal Pregnancy with Live Fetus at Term at the South N'djamena District Hospital. A Case Study

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Abstract

A case of abdominal pregnancy with live fetus at term was diagnosed in a patient living in the rural area of N'Djamena and who had no follow-up. The laparotomy made it possible to extract a healthy child without any defect. The maternal prognosis was marked by anemia related to cataclysmic hemorrhaging during surgery.

Key words: abdominal pregnancy with fetus at term, maternal-fetal prognosis.

Abdominal pregnancy is defined as the primary, or more often secondary, implantation and development of the fertilized egg in whole or in part within the abdominal cavity[1,2]. The types that evolve to term are exceptional with high perinatal mortality and maternal complications such as occlusive disease, infections and especially hemorrhage can be very serious[3-8].

For Correa[6] the abdominal pregnancy is one of the results of underdevelopment. We report a case of abdominal pregnancy with term fetus at the South N'Djamena District Hospital in Chad.

CASE REPORT:

Ms. T. D, 33 years old, Housewife (living in the rural area of N'Djamena), 4th gestation primipara with a live child, two miscarriages, was referred by a peripheral health center to South N'Djamena District Hospital on September 21, 2013 at 10:15 with intermittent abdominal pain, persistent vomiting, frequently postprandial, and unknown term pregnancy.

The onset of symptoms was several weeks marked by nausea, vomiting and early postprandial disorder and transit type constipation. The occurrence of abdominal pain, especially during fetal movement, motivated consultation at the health center. The persistence of these symptoms explains the reference to South Ndjamena District Hospital for better care.

Pregnancy had not been followed, the previous delivery was done by vaginal delivery and the medical record indicates that the patient was treated for left salpingitis at the referring clinic 1 year and 4 months ago.

The admission examination noted a conscious patient, complaining of abdominal pain and vomiting. The general examination revealed a malnourished patient weighing 42kg with a height of 156cm, conjunctival mucosa lightly colored, a blood pressure 90/60 mmHg, radial pulse 85 bpm and a temperature of 37.2 ° C.

Physical examination: The abdomen was enlarged, distorted and asymmetric, the height was 29cm, and the presentation was transverse with fetal heart sounds heard at the level of the peri-umbilical region. On vaginal examination, the vulva was clean and the cervix was anterior, soft and closed.

The remainder of the physical examination was unremarkable.

The ultrasound (abdominal and vaginal) confirmed the diagnosis of progressive abdominal pregnancy with the fetus in transverse presentation and an estimated ultrasound term of 37 weeks and 5 days.

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The uterus was slightly increased in size with a cavity line empty, thin and median. The placenta was outside the uterine cavity at the level of the left iliac fossa, bathing in a discrete peritoneal effusion more or less organized. We concluded a scalable abdominal pregnancy with fetus at 37 weeks gestation and 5 days for which the laparotomy was indicated.

The laparotomy was performed under general anesthesia to the median, lower umbilico-suprapubic area and a live fetus contained in its amnio-chorionic membranes was found in the abdominal cavity. After opening the membranes, a living female child was delivered weighing 2250 g, APGAR 8-10 and showing no malformation. After cord clamping, exploration found a placenta adhering to the omentum, a little on the handles, the fundus and left appendices on the uterus. This produced cataclysmic hemorrhaging, and the placenta could easily detach which reduced bleeding. The hemostatic control was achieved with the section of the left utero-ovarian vascular pedicle, the left round ligament and the left annexes completed by the realization of two stitches to the fundus. A drain was placed.

The blood loss was compensated intraoperatively by transfusion of 4 units packed red blood cells type (O +).

The postoperative course was simple with discharge at the 7th postoperative day.

DISCUSSION:

Frequency and maternal characteristics: The frequency of abdominal pregnancy varies by region. It is higher in countries with low medical density and diagnosis is also higher[6,8]. The large variability in incidence of the disease depends primarily on the country's socio-economic level and quality in monitoring of pregnancy[2,6,9] but also to the high prevalence of sexually transmitted diseases, resulting in tubal damage commonly seen in Africa[8]. This assertion remains valid in our case; our patient had a history of pelvic inflammatory disease and never had a prenatal visit.

Diagnosis: Clinically, several symptoms are used to guide diagnosis[10-11]:

- Digestive disorders: nausea, vomiting;
- Abdominal and pelvic pain concomitant with fetal movement if the fetus is alive, with or without bleeding;
- Anemia at impaired general condition;
- A very superficial fetus often atypical high transverse position;
- Sometimes a progressive complication of internal or external hemorrhage, or toxic syndrome;
- On vaginal examination, the cervix is often set in the pubic symphysis, it is hard and long.

Many of these signs are found in our patients, which had attracted our attention on the abdominal pregnancy. However, the ultrasound was valuable in our case to confirm the diagnosis. It enabled us to visualize. The ultrasound is the only confirmatory examination related to our technical platform.

Treatment: Surgery is the only therapeutic treatment used to support an abdominal pregnancy. The emergency operation is theoretically due to the fetal viability[2,12]. In our case, when the fetus is at term, the laparotomy was performed without delay.

The decision as to the placenta depends on its insertion. Because of the risk of uncontrollable bleeding associated with placental insertion, any attempts at extraction is strictly prohibited if the placenta is part of a major organ or a vessel[7,9,11,13]. The detachment of the placenta observed in this case is attributed to cataclysmic hemorrhage. Bleeding allowed the easily detachment of the

placenta. However it should be noted that thanks to the left adnexectomy, the section of the left utero-ovarian vascular pedicle, and the left round ligament that hemostasis is achieved. Our action is similar to that of[14] who made the adnexectomy and the section and ligature of the vascular pedicle in front of cataclysmic hemorrhage.

Prognosis: The fetal prognosis is poor with mortality between 75% and 95% due to the defective vascularization of the placenta (premature aging) with low birth weight and fetal malformations[8,13,15]. Our newborn at term had no malformation but hypotrope for its term.

As for maternal prognosis, it depends on the delay in diagnosis and action taken in respect of the placenta[8,15]. Anemia observed in our case postoperatively is explained by the detachment of placenta.

CONCLUSION:

Abdominal pregnancy is a result of underdevelopment; its impact depends mainly on the socio-economic level of the country and the quality of care for pregnant women, but also to the high prevalence of sexually transmitted diseases. Surgery is the only therapeutic action; the intervention for the placenta depends on its insertion.

Conflict of Interest

All author have declared that there is no conflict of interest whatsoever

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