Advanced Extrauterine Pregnancy With Delivery of a Living Child: A Case Report.

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Abstract

Although abdominal pregnancy had been well documented, such pregnancies exceptionally reach term but delivery of a live infant is rare. We report a case of abdominal pregnancy diagnosed at 25weeks and managed conservatively with the delivery of a live baby that weighed 2.8kg. The problems encountered in the management are highlighted.

Key Words: Extrauterine Pregnancy, Ectopic Gestation. [Trop J Obstet Gynaecol, 2004;21:180-182]

Introduction

Tubal abortion followed by secondary implantation of the gestation sac in an adjacent organ is generally considered as the origin of most abdominal pregnancies. Advanced abdominal pregnancy is a rare event with a high fetal and maternal morbidity and mortality [1].Once the diagnosis is made, management of the patient requires a careful evaluation to improve the outcome. In this communication, we report a case diagnosed in the second trimester and successfully managed conservatively until delivery at 35 weeks.

Case Report

Mrs. J.A, a 23-year-old gravida [1] para[0] illiterate farmer was referred with abdominal pain of one-month duration, following six months amenorrhoea. She was not definite about the exact date of her last menstruation. The pain, which was initially dull, has increased in frequency and intensity in the last one week prior to presentation. There was associated nausea with occasional vomiting which consisted of clear fluid. There was no history of fainting attack. She had painless spotting of blood per vaginam on three different occasions at three months gestation. She did not seek medical advice then. She had a regular menstrual cycle of 28-30 days with 4 days of menstrual flow. There was associated primary dysmenorrhea but no previous history of pelvic infection or contraceptive use. She had some analgesics at the referral hospital.

The patient was in painful distress but her vital signs were satisfactory. She was afebrile, anicteric and not pale. The abdomen was full, tender and symphysio-fundal height corresponded to gestational age of 22 weeks. Further abdominal examination was not possible because of tenderness. Pelvic examination revealed a closed cervical os. Her packed cell volume (PCV) was 34% and abdominal ultrasound confirmed 25 weeks viable extra uterine pregnancy. The diagnosis and conservative approach to management with the patient on hospital admission were discussed with the patient and her husband. She was placed on analgesics and haematinics. The patient did daily fetal movement count and a weekly ultrasound examination to monitor the fetal growth and cardiac activity. Also 3 pints of fresh whole blood were always kept ready in the blood bank and her PCV was done weekly. She remained in the ward until 35 weeks when a decision was taken to deliver the baby because of increasing abdominal pains. The neonatologist was informed.

At operation, the gestation sac containing scanty liquor was found buried in the greater omentum within the peritoneal cavity. The placenta was adherent to the colon posteriorly and to the anterior abdominal wall anteriorly. It covered the anterior and inferior aspect of the gestation sac. Both ovaries and tubes were normal and the empty uterus was about 14 weeks size of pregnancy. A live female baby that weighed 2.8 kg, was delivered and had an Apgar score of 8 and 10 at one and five minutes respectively. There were some pressure bands on the right proximal phalanx of index and middle fingers. Omentum was firmly adherent to the baby's hairs. The whole placenta was left in situ in the peritoneal cavity and the estimated blood loss was one litre. Two pints of blood was transfused intra-operatively. She had a prolonged and turbulent post-operative recovery associated with fever and evidence of intra-peritoneal fluid collection, which was confirmed with ultrasound. This necessitated the use cephalosporins and a repeat laparotomy on the 21st day after the initial surgery to drain the abscess. She was subsequently discharged home seven days later with a PCV of 30%. The total duration of hospital stay from the time of first surgery was 28 days.

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Figure 1 showing the omentum and placenta on opening the peritoneal cavity

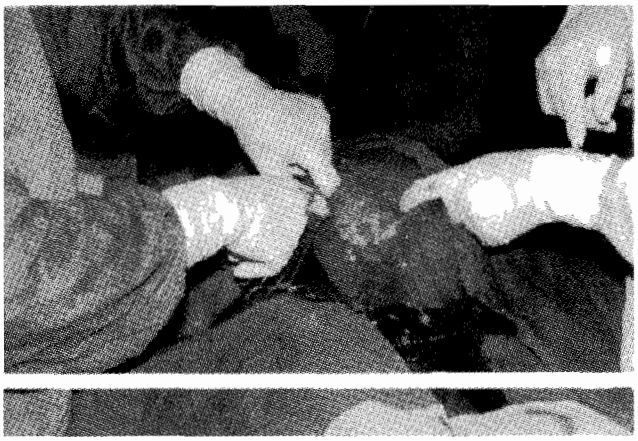

Figure 2: The baby been extracted from the peritoneal cavity.

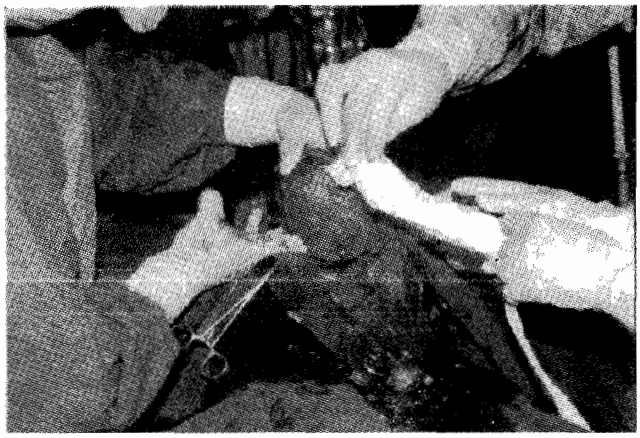

Figure 3: Omentum adherent to the baby's hair

Discussion

Abdominal gestation is a relatively uncommon complication of pregnancy. They are seen once in every 10,000 birth in United States [2] and one in 9500 deliveries in Zimbabwe [3]. Although this condition had been Documented, it still remains a serious dilemma for most clinicians in the contemporary obstetric practice because of the difficulties in early diagnosis and proper management.

Abdominal pain as in this patient remains the most frequent symptom but physical examination is often inconclusive. Ultrasound is currently the imaging method of choice for establishing gestational location and in assessing ongoing pregnancy but sonographic interpretation may be difficult due to gas within the gastrointestinal tract and distorted pelvic anatomy [4,5].The complimentary role of magnetic resonance imaging (MRI) has been described [4].

Once the diagnosis of abdominal pregnancy is made management of the patient requires a careful and further evaluation. While most clinicians agree with immediate operative intervention for those pregnancies prior to 24 weeks because of poor fetal prognosis, there is debate concerning the appropriateness of a more conservative approach in patients who present after 24 weeks [2].The decision to risk conservative management in the hope of achieving a viable pregnancy was because of adequate back-up for immediate intervention (including blood for transfusion) and good ultrasound facility for the dual role of monitoring the fetal growth and cardiac activity. This was further strengthened by reported decrease in maternal mortality and improved survival rate of live born infant [6].

Cases of advance abdominal pregnancy in which the baby was delivered alive has been reported in various parts of the world [3, 7]. The present case is interesting because the diagnosis was made at 25 weeks (as against most term abdominal pregnancies that were diagnosed in labour) and conservative management undertaken until a viable pregnancy was achieved.

At laparotomy, management of the placenta is the greatest problem. The best results are obtained if the placenta can be removed safely but partial removal is the most hazardous procedure and should not be undertaken [8]. Hemorrhage during or after surgery, pelvic abscess and prolonged febrile morbidity can complicate the puerperal course of the gravida after removal of an extra-uterine fetus with non-disturbance of the extra-uterine placenta [9]. The placenta that was left in-situ contributed to the stormy convalescence in this patient. Despite the significant maternal morbidity, maternal death is rare [1]. Fetal morbidity and mortality is generally high. The survival rate of live born infants of 30 weeks or more gestation in America was 63 percent [6]. Pressure deformity evident in this baby has been reported as very common [3].

In conclusion, the conservative management of abdominal pregnancy to achieve a viable fetus poses a great challenge to the obstetrician. With adequate facilities and good judgment, such management has been found most rewarding.

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