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THE 30TH WEEK GESTATION TUBAL AND INTRALIGAMENTARY ABDOMINAL PREGNANCY WITH MATERNAL AND FETAL SURVIVAL: A CASE REPORT

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Abstract- Abdominal pregnancy is a rare obstetric emergency with the high maternal and fetal morbidity and mortality rates. The diagnosis of abdominal pregnancy is often intrasurgical at either diagnostic laparoscopy or laparotomy. The diagnosis and management of a woman with an abdominal pregnancy in the right round ligament and fallopian tube, which resulted in a live, healthy 30th week gestation infant, was presented in this case report. Although the characteristics of abdominal pregnancy were the history of an abdominal pain early gestation in pregnancy, ultrasonographic appearances and increased alpha-fetoprotein, the correct diagnosis might not be established until laparotomy. The salpingectomy was performed to prevent abundant hemorrhage for retained placenta. The operation was ended with maternal and fetal survival. Laparotomy should be suddenly preferred in gynecological emergencies for the diagnosis and treatment.

Keywords- Abdominal pregnancy, laparotomy

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Introduction

Abdominal pregnancy is a rare obstetric emergency, occurring in 1 in 10000 pregnancies [1]. Laparotomy is performed because it is medical emergency for the high maternal and fetal morbidity and mortality. The tubal or intraligamentary pregnancy resulting in a live infant is reported [2]. We presented an abdominal pregnancy within the tubal and intraligamentary placental invasion with maternal and fetal survival.

Material and Methods

A 19-year-old woman, primigravida in 30 weeks of gestation of pregnancy admitted to our clinic, complaining with a suddenly began abdominal pain. Her past medical, gynecological, and surgical histories were unremarkable. At the gestation stage of 18 weeks routine screening consisted of triple screen, maternal serum α-fetoprotein (MSAFP) was high. Therefore, at 22 gestation weeks ultrasound evaluation of fetal anatomy was performed for the major structural anomalies such as neural tube defects and it was normal.

Result

On admission to hospital, the patient's blood pressure was 90/60 mmHg and pulse rate was 120 beats/minute. Physical examination revealed pale skin, sweating, and diffuse tenderness of the abdomen. On gynecological examination there was not found any evidence for antepartum bleeding. Ultrasound examination disclosed massive hemorrhage in the abdomen and fetal bradycardia (88 beats/minute). The haemoglobin level was 7.8 g/dl. With a presumptive diagnosis of uterine rupture and fetal distress, the patient underwent an exploratory laparotomy. At surgery, the breach positioned fetus was found and delivered, weighing 1200 g with an APGAR score of 6-8 at 1-5 minute [Fig-1]. The amniotic membranes were adherent to the loops of the jejunum and ileum and were easily dissected away. The placenta was adherent to the right round ligament and fallopian tube [Fig-1]. Typical salpingectomy was carried out. The uterus was normal in size. The postoperative course was normal.

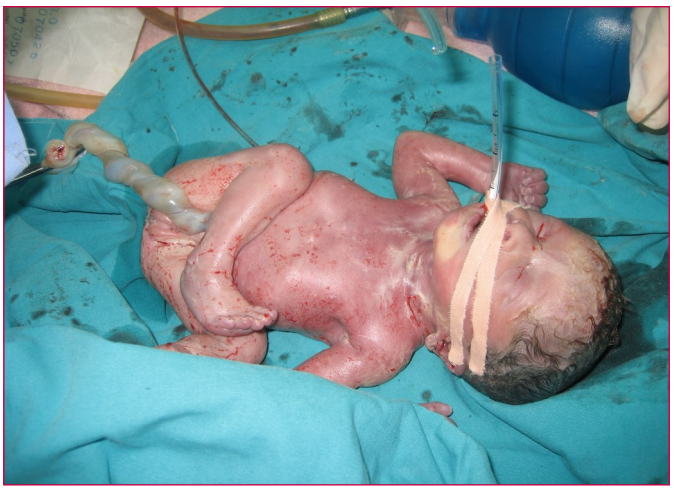

Fig. 1- Alive fetus

Discussion

In all of the ectopic pregnancies, the incidence of abdominal pregnancy is 1.6% [3]. Abdominal pregnancies are potentially life threatening so laparotomy is performed. Massive haemorrhage complicates such pregnancies as hypertrophied vessels constrict poorly. Abscess, adhesion and intestinal obstruction might occur for retained placental elements. Arterial embolisation of specific bleeding sites has been shown to be another life-saving procedure in uncontrolled haemorrhage [4]. The treatment for abdominal pregnancy has traditionally been laparotomy. In this case, 30th week gestation abdominal pregnancy was delivered by laparotomy.

The diagnosis of abdominal pregnancy is often intrasurgical at either diagnostic laparoscopy or laparotomy [5]. Many misdiagnoses had been described [6-7]. The main difficulty is physicians do not readily keep in mind the possibility of this rare condition. Fetal malpresentation, malformations or oligohydramnios are helpful to suspect this condition [8-10]. Also the finding of an abnormally high maternal serum alfa-fetoprotein has been proposed [11]. In our opinion, sometimes these methods have not been beneficial and the essential diagnosis may identify during laparotomy.

The main problem encountered at operation is whether or not to remove the placenta. Separating it may lead to abundant haemorrhage, and leaving it in situ may result in abscess formation [12]. Removal may be undertaken with the possibility of safe ligation of the vessels supplying the placenta [13]. Therefore, the treatment of the placenta after delivery, salpingectomy was preferred for the high risk of maternal mortality.

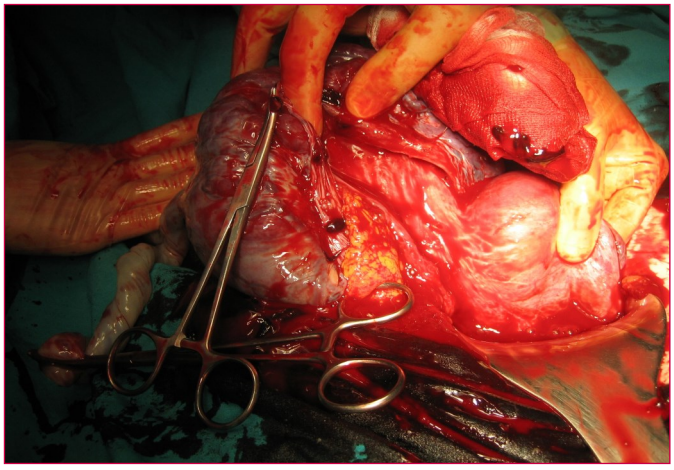

Fig. 2- Placental view

Conclusion

The rarely seen case of a woman with an abdominal pregnancy in the right round ligament and fallopian tube, which resulted in a live, healthy 30th week gestation infant, was presented. We emphasize that the rapid evaluation is highly important in gynecological cases and the main diagnosis of gynecological emergencies might be surgical. Although the characteristics of abdominal pregnancy were the history of an abdominal pain early gestation in pregnancy, ultrasonographic appearances and increased alpha-fetoprotein, the correct diagnosis might not be established until laparotomy.

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Conflicts of Interest: None declared.

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