INTERNATIONAL JOURNAL OF HEALTH & MEDICAL RESEARCH

ISSN(print): 2833-213X, ISSN(online): 2833-2148

Volume 02 Issue 01 January 2023

Page No. 09-12

Abdominal Ectopic Pregnancy with a Living Fetus in Multiparas at 31 Weeks of Gestational age

Reski Wulandari Roni[1], Ketut Widaya[2]

[1]General Practitioner, East Borneo, Indonesia

[2]Obstetric and Gynecology Specialist, East Borneo, Indonesia

ABSTRACT: Ectopic pregnancy is a condition in which the gestational sac is outside the uterine cavity, and is the most life-threatening emergency condition in early pregnancy. Ectopic pregnancy causes 28% of maternal deaths in the world. The incidence of ectopic pregnancy increased from 1.4% to 2.2% of live births. Abdominal pregnancy is one of the classifications of ectopic pregnancy. Abdominal pregnancy is defined as a pregnancy in which implantation occurs in the abdominal cavity without involving the fallopian tube, ovary or intraligamentary implantation. The incidence is 1:402 pregnancies in developing countries and 1:10000 pregnancies in developed countries. Abdominal pregnancy occurs as a result of uterine rupture or tubal abortion (secondary abdominal pregnancy) or less commonly as a result of direct implantation of the peritoneum with normal fallopian tubes, normal ovaries and absence of tubal fistulas (abdominal primary pregnancy). We report a case of a 22-year-old woman with an abdominal pregnancy at 31 weeks' gestation and a live fetus was found but the mother was anemic with a hemoglobin value of 6.6 g%, requiring a transfusion of 4 blood bags. The patient's condition improved 3 days postoperatively with close monitoring in the Intensive Care Unit (ICU).

KEYWORDS: Abdominal Ectopic Pregnancy, Living Fetus, Multiparas

I. INTRODUCTION

Pregnancy health problems in women of reproductive age whose products of conception implant outside the endometrium. One of the variants of ectopic pregnancy is abdominal ectopic pregnancy. Abdominal pregnancy is defined as a pregnancy in which implantation occurs in the abdominal cavity without involving the fallopian tubes, ovaries or intraligamentary implantation. Late abdominal pregnancy is defined as a pregnancy with a gestational age of more than 20 weeks in which the fetus is alive, or showing signs of having lived and developed, in the mother's abdominal cavity. It is often difficult to diagnose before surgical intervention and tends to have quite dangerous complications. Abdominal pregnancy is a very rare occurrence. According to Ombelet et al, the incidence is 1: 402 pregnancies in developing countries and 1:10.000 pregnancies in developed countries. Abdominal pregnancy occurs as a result of uterine rupture or tubal abortion (secondary abdominal pregnancy) or less commonly as a result of direct implantation of the peritoneum with normal fallopian tubes, normal ovaries and absence of tubal fistulas (abdominal primary pregnancy).

The maternal mortality rate caused by abdominal pregnancy has been reported to range from 0.5% -18%. Associated morbidity is due to bleeding, infection, anemia, DIC, pulmonary embolism, and gastrointestinal fistulas that arise due to the presence of fetal bone. Perinatal morbidity ranges from 40-95% even if the pregnancy is continued to term, and 20-40% of fetuses are accompanied by congenital abnormalities, mostly due to oligohydramnios. Abdominal pregnancies mostly occur in ectopic is developing countries, this may be due to the high incidence of PID with suboptimal treatment. A case regarding a 22-year-old woman with an abdominal pregnancy at 31 weeks' gestation and a live fetus was found but the mother was anemic with a hemoglobin value of 6.6 gr%, requiring a transfusion of 4 blood bags. The patient's condition improved 3 days postoperatively with close monitoring in the Intensive Care Unit (ICU). This case has received approval from the patient and the hospital medical committee to serve as teaching and science material.

II. PURPOSE

To present a rare case of abdominal pregnancy. Discusses the theory and management of Abdominal Pregnancy.

III. CASE REPORT

A 22 year old woman, multiparous on 31 weeks gestation complaining of pain in the abdominal area every time the fetus moves. The patient also complained of heartburn which began to be felt routinely. The patient is known to have never done ultrasound or AnteNatal Care in this pregnancy. From the physical examination and ultrasound performed at the hospital, it was found that the

ultrasound examination found that the fetus was not bounded by the uterine wall, no membranes and amniotic fluid were found covering the fetus and no uterine wall was found between the fetus and the urinary bladder. Ultrasonographic findings in abdominal pregnancy often do not allow a definitive diagnosis. Laboratory results before surgery showed a significant anemia rate with a haemoglobin level of 6.6 gr%, Leukocytes 7.580 mm3, Platelets 270.000/μL,

The patient was then directed to be hospitalized and his general condition was improved to overcome the anemia that occurred in the patient by giving a transfusion of 4 blood bags. The patient was planned for a laparotomy to deliver the baby the next day. In this case a laparotomy was performed with an indication of abdominal pregnancy. During the operation, the amniotic sac was found to be covered with omentum (adhesions), then adhesiolysis was performed and the amnion wall was broken by hooking the leg. Then a baby girl was born who was still alive with a weight of 1370 grams, a body length of 36 cm with an APGAR score of 8-9. Placental implantation on the right side of the abdominal cavity extends into Douglas's cavity. There was no visible active bleeding from the placental implantation site, the placenta was then left in the abdominal cavity after the umbilical cord was cut as short as possible and then tied with 2.0 silk thread

IV. CASE DISCUSSION

Pregnancy health problem for women of reproductive age because it is the leading cause of death in the first trimester of pregnancy in the United States, which is 9% of all deaths in pregnancy. The frequency of ectopic pregnancy is 1% of all pregnancies and 90% of cases occur in the fallopian tube. Apart from the fallopian tubes, ectopic pregnancies can also occur in the ovaries, cervix or abdominal cavity. Abdominal pregnancy is a rare but life-threatening variant of ectopic pregnancy. This occurs when the gestational sac implants outside the uterus, ovaries, or fallopian tubes. Abdominal pregnancy can be divided into two, namely primary abdominal pregnancy and secondary abdominal pregnancy. Primary abdominal pregnancy less common than secondary. The diagnosis of abdominal ectopic pregnancy must meet the criteria, the fallopian tubes and ovaries are normal, the absence of fistulas from the ruptured uterus, the attachment of products of conception only to the peritoneum. Pregnancy occurs when the placenta from a pregnancy in the tube, cornu and uterus expands and attaches to the surrounding serous tissue. Typically an abdominal pregnancy begins with another ectopic pregnancy that spreads out of the tube and adheres to the surrounding tissue. In addition, it can also occur due to rupture of the former cesarean section incision.

To diagnose abdominal pregnancy is not easy. The first step is anamnesis, in primary abdominal pregnancies if symptoms of pain or cramps in the abdomen and vaginal bleeding are found, we must be suspicious, unfortunately not all women show such typical symptoms. abdominals secondary. The initial clinical symptom that is often found in women with abdominal pregnancies is pain in the abdomen. Other symptoms associated with implantation of the placenta in the bowel or bladder produce symptoms of obstruction or inflammation. Characteristics of abdominal pregnancy on ultrasound examination found a fetus outside the uterus and no uterine wall found between the bladder and the fetus, extrauterine location of the placenta, poor visualization of the placenta, oligohydramnios, parts of the fetus adjacent to the abdominal organs Mother. In abdominal pregnancy, most of the diagnoses of pregnancy are not made when the patient first arrives, although there are several clues and diagnostic tools such as ultrasound, x-rays and phytosine tests, the diagnosis of pregnancy Abdominal pregnancy really depends on whether there is any thought of the possibility of abdominal pregnancy. Diagnostic errors range from 50% to 90%

A. Medical History

There is suspicion pregnancy abdominal pain in this patient was obtained from the history of pain in the abdomen every time the fetus moved, pain accompanied by difficulty breathing every time the fetus moved. In an abdominal pregnancy, the usual anamnesis of multiparas might say that the current pregnancy is "not as usual". Abnormalities that may be remembered include irregular bleeding together with abdominal pain which is usually most prominent in one or both lower quadrants. Pregnancy may also last until full months. If this time is reached, the patient feels contraction like going into labor (spurious labor).

B. Physical examination

On physical examination, it was found that the parts of the fetus were easier to touch, there was a mass in the abdomen that was separated from the uterus. Suspicion pregnancy

C. Laboratory Examination

Laboratory tests that can be done are serum and urine tests for HCG. Serial HCG levels can differentiate ectopic pregnancies from normal intrauterine pregnancies. At 6-7 weeks of gestation, serum HCG levels are doubled in normal intrauterine pregnancy. An increase of ≤66% is seen in 85% of nonviable pregnancies. If the ultrasound examination finds an empty uterine cavity, this indicates an ectopic pregnancy. However, serial examinations do not provide clinical benefit because it delays diagnosis, resulting in high complications that can occur. Serum level check of progesterone can also differentiate the normal intrauterine pregnancy and abnormal pregnancy, serum progesterone levels that are too high or too low suggest an ectopic pregnancy. In a large study, a progesterone level of >25 ng/ml excluded the diagnosis of ectopic pregnancy with a sensitivity of 97.4%. Progesterone level ≤5 ng/ml excludes normal intrauterine pregnancy with 100% sensitivity.

D. Utrasound Examination

On ultrasound examination found that the fetus was not bounded by the uterine wall, no membranes and amniotic fluid were found covering the fetus and no uterine wall was found between the fetus and the urinary bladder. Ultrasonographic findings in abdominal pregnancy often do not allow a definitive diagnosis. Ultrasound diagnosis of abdominal pregnancy can be missed in 50% of cases. Akhan et al. (1990) reported the following ultrasonographic criteria to be suggestive of abdominal pregnancy:

1) Visualization of the fetus separated from uterus.
2) Failure to visualize the uterine wall between the fetus and bladder, (3). The fetal parts are very close to the mother's abdominal wall.
3) Eccentric position (relationship between fetus and uterus) or relationship between fetal parts and other fetal parts abnormal and visualization of extrauterine placental tissue

For abdominal pregnancy there are several things that must be considered, that is complications experienced by the mother, congenital abnormalities of the fetus, gestational age, availability of facilities determine governance neonatal care. A dead fetus is an indication for surgery, to avoid the risk of infection, bleeding, and DIC. The principle of surgery for abdominal pregnancy is delivery of the fetus as soon as possible and careful assessment of the placental implantation site. Removal of the placenta can trigger massive bleeding because there is no myomterial contraction mechanism to clamp the hypertrophied blood vessels. This can occur spontaneously or while the clinician is trying to locate the actual implantation site of the placenta. Therefore it is highly recommended to avoid unnecessary exploration of the surrounding organs. Leaving the placenta in place can also cause several complications such as infection, abscesses, adhesions, intestinal obstruction, and open wounds.

V. CONCLUSIONS

Abdominal pregnancy is one type of classification of ectopic pregnancy. In this case there is only 1 way of delivery, namely by sectio caesaria because the pregnancy occurs in the abdomen and it is not possible to be born spontaneously. Good management will reduce the possibility of death in the mother or not at all.

ACKNOWLEDGMENT (SIZE 10 & BOLD)

The author would like to thank doctor Ketut Widaya Obstetrics and Gynecology Specialist for guidance and direction in this writing.

REFERENCES

1) Cunningham FG, Leveno JK. Abdominal pregnancy. In : Wiliams Obstetrics 23rd edition. MC Graw Hill 2010: page 249-51.
2) Brewster EM, Braithwaite EA. Advance abdominal pregnancy - A case report of good maternal and perinatal outcome.West Indian Med Journal 2011; 60(5):587-9.
3) Zhang J, Li F, Sheng Q. Full-term abdominal pregnancy: a case report and review of theiterature. Gynecol Obstet Invest. 2008;65(2):139
4) Sarwat A, Awais N,. Abdominal pregnancy A Diagnostic Dilema . Professional Medical Journal 2011;18(3):479-84
5) Nkusu ND, Einterz EM. Advance abdominal pregnancy : case report and review of 163 case reported since 1946. Rural Remote Health. 2008 Oct-Dec;8(4):1087. Epub 2008 Dec 1.
6) Kshirsagar A.Y, Pujari S, in A live intra Abdominal pregnancy : A Case Report. Journal Obstetric and Gynecology India 2010; 60(2):157-159.
7) Bertrand G, Le ray C, Simard-emond L, Dubois J, Leduc L. Imaging in the management of abdominal pregnancy: A Case Report and review of the lliterature. J Obstet Gynecol 2009; 31(1):57-62
8) Baffoe P. Fofie C, Gandau BN. Term abdominal pregnancy with healthy newborn:A case report in Ghana Medical Journal 2011 Jun;45(2):81-3.
9) Molinaro TA, Barnhart KT. Abdominal Ectopic Pregnancy. Available from
10) Sepilian VP, Wood E. Ectopic pregnancy [internet]. New York: Medscape; 2015 [diakses pada mei 2016]; tersedia dari: http://www.emedicine.medscape.com/ar ticle/2041923-overview.
11) Kumar V, Abbas AK, Aster J. Robbins basic pathology. Edisi ke-9. USA: Elsevier; 2013.
12) Tay JI, Moore J, Walker JJ. Ectopic pregnancy. West J Med. 2000; 173(2):131-4.
13) Kun KY, Wong PY, Ho MW, Tai CM, Ng TK. Abdominal pregnancy presenting as a missed abortion at 16 weeks gestation. Hong Kong Med J. 2000; 6(4):425-7.
14) Klatt EC. Robbin and cotran atlas of pathology. Edisi ke-3. Philadelphia: Elsevier; 2014.
15) Galluzzo RN, Cardoso GM, Santos ML. Abdominal pregnancy. [Place unknown]: [Publisher unknown]; 2006
16) Scheid DC, Ramakrishnan K. Determining ectopic pregnancy risk using progesterone levels. Am Fam Physician [internet]. 2006.

17) Jazayeri A, Davis TA, Contreras DN. Diagnosis and management of abdominal pregnancy: a case report. J Reprod Med [internet]. 2002
18) Huang K, Song L, Lu Y, Wang L, Gao Z, Meng Y. Advanced abdominal pregnancy: an increasingly challenging clinical concern for obstricians. Int J Clin Exp Pathol. 2014; 7(9):5461-72.
19) Radhakrishnan K. Radiological case: intra- abdominal pregnancy. J Pract Med Imaging & Manage [internet]. 2015. [diakses pada juni 2016]; htp://www.appliedradiology.com/articles /radiological-case-intra-abdominal- pregnancy.