

A CASE OF ABDOMINAL PREGNANCY

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Abstract- Abdominal pregnancies are very uncommon and are misdiagnosed in half of the cases. We describe a case of abdominal pregnancy, which was misdiagnosed as pregnancy in a bicornuate uterus. The patient underwent operation urgently because of unstable hemodynamics. The spontaneously separated placenta and its bleeding site in the Douglas pouch were seen. We could not use sutures for hemostasis so, the place was managed by gauze packing and the minor postoperative complications were managed appropriately. It seems that packing with gauze is a good option for these cases.

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Key words: Abdominal pregnancy, laparotomy, bicornuate uterus, extrauterine pregnancy, ectopic pregnancy, management

INTRODUCTION

Abdominal pregnancies are very uncommon. According to the Center for Disease Control, incidence of abdominal pregnancy is 1 in 10,000 live births and compose approximately 1% of ectopic gestations. Diagnosis is mostly made by laparoscopy or laparotomy, because ultrasound often fails to reveal the implantation site and symptoms may be absent (1).

When recognized at previable gestational ages, immediate laparotomy with removal of the fetus is usually recommended because of the maternal risks of life-threatening hemorrhage and the generally poor fetal prognosis. In cases in which placental implantation has occurred in vascular areas, it has been recommended that the placenta be left *in situ*, because surgical excision can result in uncontrollable and life-threatening hemorrhage (2). The risk of dying of abdominal pregnancy is 90 times greater than with an intrauterine pregnancy (3) and 8 times greater than the risk of dying from a tubal pregnancy (4). Here we report a case of abdominal pregnancy misdiagnosed as pregnancy in a bicornuate uterus.

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CASE REPORT

A 35-year-old multigravida (G 4) patient was admitted at 14 weeks of amenorrhea. She reported having two abortions and a live child. She did not have any spotting during pregnancy but sometimes felt pain in her right iliac fossa.

On examination we had a stable patient with no signs of peritonism. Bimanual pelvic assessment revealed a non-tender, large uterus with a closed external cervical os, without any bleeding or tenderness. It was difficult to differentiate the mass from the uterus because of the patient's obesity.

One of the pelvic ultrasonographic scannings demonstrated a bicornuate uterus with a 14 weeks fetus in the right cornua. The left cornua was empty and the fetus had normal activity. Two other pelvic ultrasonographic examinations done by other radiologists reported an empty uterus with 25 mm endometrium (Fig. 1).

These scans showed a normal left adnexa and 14 weeks live fetus in the side. There was no free fluid in the pouch of Douglas.

Since we had an asymptomatic patient with a controversial ultrasonographic reports, we admitted her for evaluation by laparoscopy.

A few hours after admission, the patient suddenly felt a sharp severe pain in her lower abdomen and developed hypotension and tachycardia.



Fig. 1. Sonogram of the patient at the 14th week of gestation.

She was carried to the operating room and laparotomy was done with a vertical incision. There was about two liters of blood, a 14-week fetus and its placenta in the peritoneal cavity. After evacuating the blood from the abdominal cavity we searched for site of placental insertion. The uterus was large without any defects. Both the fallopian tubes and ovaries were intact. The site of placental insertion was in the Douglas pouch. Hemorrhage from this site was very severe; the peritoneal surface of the anterior rectal wall was also bleeding.

We were not able to suture the site of placental insertion and because of active hemorrhage we compressed the site as tightly as possible by gauze packing. We used gauze packing in the vagina too. The patient received five units of whole blood and three units of fresh frozen plasma in the operating room. The day after, the general condition of the patient was good, but the abdomen was distended. About 36 hours after the operation, the distention increased greatly so the patient was returned to the operating room and the pack was removed. The level of hCG was 41500 IU one day after operation. Three days after the first operation the patient got diarrhea and *Entamoeba Histolytica* was found in the stool examination. The patient was treated with metronidazole (750 mg TID).

After two days, a temperature of 38.5 °C was detected. Because of suspicion of a pelvic abscess,

CT scan of the pelvic was done and an abscess with a diameter of about 7 cm was detected behind the uterus. Broad-spectrum antibiotics were started (cephalothin 1 gr QID IV, gentamicin 80 mg TID IV, metronidazole 750 mg TID IV) but fever persisted for next three days. Vaginal sonography was done at that time and a 6 x 7.5 cm abscess was seen in the Douglas pouch. The abscess was drained under the guidance of vaginal sonography and about 250 cc pus was evacuated. Fever stopped after drainage of the abscess. After 18 days of hospitalization the patient was discharged in an excellent condition and a negative hCG.

DISCUSSION

Diagnosis of abdominal pregnancy continues to be a challenge, resulting in delays in diagnosis and decision making (5). Even in ideal conditions a sonographic diagnosis of abdominal pregnancy is missed in half of the cases (6).

Ramachandran *et al.* report a case of previously undiagnosed abdominal pregnancy diagnosed at the time of cesarean section carried out for a persistent oblique lie. Delivery of the fetus was followed by near catastrophic hemorrhage. A portion of the placenta was non-resectable and following surgery the patient was sent to the intensive care unit. The patient continued to lose blood and was returned to

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the operating room soon after. The abdomen was packed with large swabs and the wound left open (7).

In our patient, a center with a good experience of sonography reported a bicornuate uterus with pregnancy in the right cornua. The management of these cases is very different from abdominal pregnancy. In cases that we are not sure about the abnormality of the uterus it is better to do a diagnostic laparoscopy or MR Imaging as soon as possible (8). MRI may be considered as the gold standard (9). In the case of a vital emergency, excluding the opportunity of a laparoscopic exploration, the correct diagnosis of an abdominal pregnancy has to be made by open surgery (10). In abdominal pregnancy, we should not separate the placenta but gradual placental separation occasionally occurs spontaneously. In our patient there was complete placental separation. We could not use sutures for hemostasis, so we packed the placental site. It seems that packing is a good option for these cases.

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