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Case Report of a Rare Ruptured Secondary Abdominal Pregnancy in a Low Resource Setting

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Abstract: *Abdominal pregnancy is a rare form of ectopic pregnancy in which the fetus develops outside the reproductive organs in the abdomen presenting an acute challenge to the primary care physicians and specialists. In this instance, we are presenting a case of ruptured secondary abdominal pregnancy in a low resource setting in north east rural India*

Key Word*:Abdominal; Ectopic;Pregnancy;Rruptured; Fetus.*

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I. Introduction

Abdominal pregnancy is a rare form of ectopic pregnancy in which the embryo or the foetus grows and develops outside the abdominal organs. Abdominal Pregnancies are difficult to diagnose in low resource settings as the presentation is late and early diagnosis becomes difficult. The risk factors are same as those of ectopic pregnancies, but the morbidity and the mortality rate are much higher. Primary abdominal pregnancy refers to the implantation in the peritoneum directly, whereas the secondary abdominal pregnancy refers to the reimplantation of the pregnancy from tubal, ovarian, pregnancy , rudimentary horn rupture, etc .Here we are presenting a case report of a ruptured secondary abdominal pregnancy in shock requiring immediate laparotomy in a low resource setting in rural Northeast India.

II. Case Report

A 42 year old woman P3L2 belonging to a low socio economic status presented to the emergency of our district hospital with complaints of sudden fainting, pain abdomen and spotting per vagina with BP 70/40 PR 140 BPM and no probable history of amenorrhea. On examination urine pregnancy test was found positive, with a distension of abdomen guarding and rigidity. Per vaginal examination revealed bloody discharge with cervical motion tenderness. Provisional diagnosis of ruptured ectopic pregnancy was made and decision for laparotomy was taken. Under general anaesthesia, laparotomy was done which revealed 3litres of hemoperitonium and ruptured right uterine cornua with placental bed implanted in the adjacent omentum, 14 weeks foetus with umbilical cord attached to placental bed. Uterine cornua was repaired and right sided salpingo oopheroctomy with left sided salpingectomy was done. Left ovary was preserved. Placental bed haemostasis achieved with hot compression mops. Abdomen was closed after achieving haemostasis and 3 units of fresh whole blood transfused intraoperatively. Post operatively the hospital stay was uneventful and patient was subsequently discharged on the fifth day.

Fig. 1. Foetus present in the abdominal cavity.

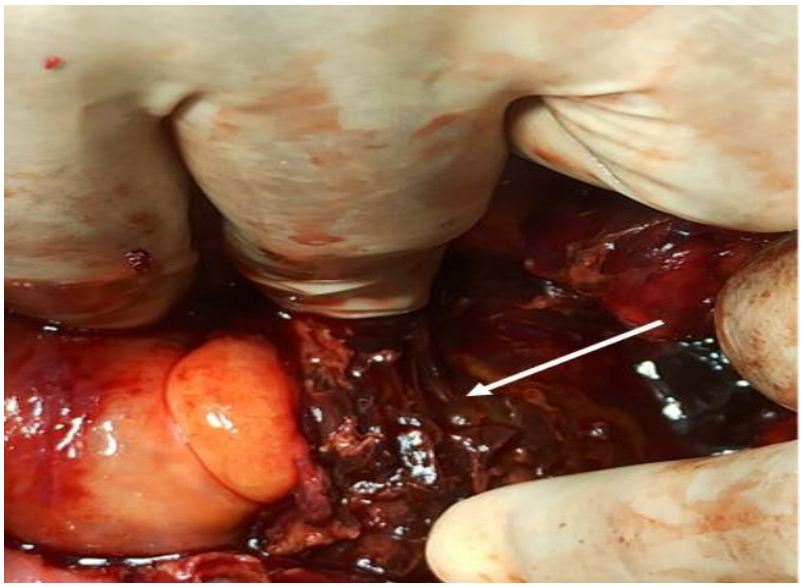

Fig. 2. Placental bed adjacent to the omentum..

III. Review of Literature

Cosentino F et al illustrated a similar case of laparoscopic management of extrauterine pregnqancy at 12 weeks of period of gestation, complicated by haemoperitonium, the authors concluded that laparoscopic management of abdominal pregnancy and heamoperitonium resulting from rupture of the gestational sac thereof was optimal.

Wong j et al reported a case of 43 year old G2P0L0A1with vaginal bleeding and lower abdominal pain. Initially a curettage was planned, but later a laparotomy had to be done because of dense adhesions, revealing a large haemoperitonium, illustrating the fact that an abdominal pregnancy can masquerade as a missed abortion

Zhang et al reported a case of secondary abdominal pregnancy which remained undetected after removal of the primary tubal lesion. The secondary abdominal pregnancy remained undetected after was located in the omentum for which a second laparotomy had to be done when the patient did not improve after the first surgery.

Okafor I et al reported a case of abdominal pregnancy in a 39 year G4P3 for which immediate surgical intervention had to be done at period of gestation at 20 weeks.placenta was removed from the right iliac fossa at period of gestation of 20 weeks along with a large of haemoperitonium.

Dubey S et al confirmed a similar case of abdominal pregnancy at period of gestation 7 weeks and 2 days, presenting with haemorrhagic shock as a result of spontaneous separation from the site of implantation.

Laparotomy was done removing 3litres of haemoperitonium and 1 kg of blood clots with separated fetus in the abdominal cavity.

IV. Discussion

One of the major concerns in early pregnancy is to differentiate between an intrauterine and an extra uterine pregnancy. Hence, one has to be careful regarding the various high risk factors and the classical triad of pain, amenorrhea and bleeding per vagina while coming to a satisfactory conclusion regarding the nature of pregnancy. In all cases, an early ultrasonography regarding the same, may not be sufficient enough and clinical signs and history taking become equally important. The age old proverb of "open and see" still holds true in the context of an ectopic minded clinician, as some of the modern methods of diagnostics might not be able in all the resource settings as illustrated in our case

V. Conclusion

From our case and the review of literature, it is clear that the diagnosis of ruptured ectopic pregnancy must not always be kept confined to tubal pregnancy alone. Secondary abdominal pregnancy , if remains undiagnosed, can prove to be much more catastrophic and all measures must be implemented to rule out any probable cause of the same.

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