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# Advanced abdominal pregnancy with life birth at 33weeks gestation: a case report

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**Abstract**
Abdominal pregnancy is a situation where the pregnancy is implanted in the peritoneal cavity exclusive of tubal, ovarian or intraligamental pregnancy. It is a very rare occurrence; it presents a diagnostic and management dilemma and can be associated with high maternal/infant morbidity and mortality. We present a case of a 27year old G3P2+0,2Alive who presented at 32weeks gestation with abdominal pain, severe Anaemia and had laparotomy and delivered a life female infant weighing 1.4kg. The patient developed sepsis, Eclampsia and had second laparotomy for placental removal.

**Keywords:** Abdominal pregnancy, placenta, live birth, eclampsia

## Introduction
Ectopic pregnancy is when pregnancy is implanted outside the endometrial cavity; abdominal type is a rare type of ectopic pregnancy [1]. Abdominal pregnancy accounts for 1% of all ectopic pregnancies [2, 3]. Cases of life births after abdominal pregnancy has been reported [4, 5] however it is very rare [6]. Being rare it had to take it consideration as a possible differential, hence complications and even death can ensure when it inadvertently ruptures and results into bleeding [5].
Hence high index of suspicion is required. In the developing countries most women book pregnancy late and thus does not have an early ultrasound scan for dating and localization of pregnancy; abdominal pregnancy can be missed with attendant complications.
Here we report a case of a 27 year old that referred from a primary health care centre with Ultrasound diagnosis of abdominal pregnancy where she presented with severe recurrent abdominal pain in pregnancy had 2 laparotomy and developed wound infection and Eclampsia.

## Case Presentation
The patient was a 27 years old Gravida 3, Para 2+0,2 alive who was not sure of her last menstrual period and conceived spontaneously, last child birth was 2years before presentation. She presented at the Emergency unit of the department of Obstetrics and Gynaecology, Federal Teaching Hospital Gombe as a referred case from a Primary Health care centre with an ultrasound diagnosis of abdominal pregnancy. She presented at the centre with complaints of progressive recurrent severe abdominal pains since the onset of the pregancy, agravated by fetal kicks and irregular scanty vaginal bleeding and occasional vomiting. On examination she was in pains, pale but with normal vital signs. Fetal parts were easily palpable par abdomen and fetal heart was present. Her admission packed cell volume (PCV) was 13% and a repeat abdominal USS revealed a live abdominal pregnancy at 32week with massive ascites, empty uterus and normal pelvic organs. She was given analgesics and had 3 units of packed red cells transfused over 3days while she had steroids for fetal lungs maturation.
Seven days after admission she had laparotomy and findings were that of massive ascitic fluid of about 5 litres, a live female baby APGAR scores of 4 and 7 at first and fifth minutes respectively, weighing 1.4Kg in a thin sac floating freely in the abdominal cavity. There was a large placenta on the left side of the abdomen adhered to structures in that region including extension into gut and omentum, with many 'angry' looking vessels. The uterus was bulky and the left ovaries and tubes could not be visualized. The umbilical cord was cut very low and the baby removed with sac while the placenta was left intact.

On day 3 post-operative patient was noticed to be having tonic clonic convulsions with blood pressure of 160/110 mmHg and proteinria of 2+. Diagnosis of post- partum Eclampsia was made and she was placed on anti-hypertensive and magnesium sulphate. However 4th day post operation, the patient had marked abdominal distension with wound infection. She had a second exploratory laparotomy with a finding of markedly enlarged left ovary with placenta implanted on it; left oophorectomy was done and placenta removed along with it.

The baby died after 3days in the Special care baby unit from complications of prematurity. The patient was discharged after 30 days in the Hospital.

## Discussion

The case is an example advanced abdominal pregnancy a rare phenomenon [2] presenting with diagnostic and management challenges [5]. The commonest presentations of Abdominal pain, irregular vaginal bleeding and easily palpable fetal part has been documented [6, 7]. Others include abnormal lie, fetal demise oligohydranious, presence of maternal intra-abdominal fluid, induction failure [8]. Pain which is the most important symptom is usually non-specific in early pregnancy and becomes more intense as pregnancy progresses leading to rupture in some cases due to mild trauma and may result in acute abdomen and even death [4]. Hence the need for early diagnosis and management, which more is feasible in the first trimester using high resolution vaginal ultrasound, quantitative measurement of B- human chorionic gonadotropin (HCG) and laparoscopy [5]. As the pregnancy advances it become increasingly difficult to diagnose.

Our patient presented severely anaemic which could be due to malnutrition and recurrent vaginal bleeding. Time was taken stabilize and build her up before the surgery and steroids given to enhanced infant survival. She option of leaving the placenta behind was a precautionary measure to prevent severe bleeding as the blood supply was not recognized [9, 10]. Methorexate was not given to shrink the placenta as it was found not to be much advantage in advanced pregnancies with a large placenta [11]. It was been found that the volume of placental tissue liberated with Methothrexate may lead to large amount of necrotic tissue, sepsis and death. When placenta is left in-situ, the patient must be followed up for paralytic ileus, peritonitis sepsis/abscesses and Pre-Eclampsia [4]. This complication did occur in the index and were managed successfully. A second laparotomy had to be done with the findings of a large left ovary with placenta implanted on it; the right ovary could not be visualized due to marked adhesions. The left ovary was removed with the placenta to minimise bleeding. There were a lot of necrotic tissues in the abdominal cavity. The abdomen was lavaged with warm saline and closed in mass. Even though the histology reported Ovary with trophoblastic tissues, there was no histological confirmation of ovarian tissues in the sac it's self, and therefore diagnosis ovarian pregnancy cannot be made.

## Conclusion

Advanced Abdominal pregnancy is rare, but can present with a lot management challenges especially in low resource setting; care should be done preferably at tertiary health facility.

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