

# Abdominal Pregnancy: A Case Report of a Viable Nondysmorphic Fetus

Oluwaseyi Isaiah Odelola, Adebayo Adekunle Akadri<sup>1</sup>, Luther Agbonyegbeni Agaga, Sijuade Ayodele Dada<sup>2</sup>

Departments of Obstetrics and Gynaecology and <sup>2</sup>Anaesthesia, Olabisi Onabanjo University Teaching Hospital, Sagamu, <sup>1</sup>Department of Obstetrics and Gynaecology, Babcock University, Ilishan-Remo, Ogun State, Nigeria

## Abstract

Abdominal pregnancy is a rare form of ectopic gestation. It accounts for about 0.4% of all cases of ectopic pregnancy, and often associated with significant morbidity and mortality. Clinical presentation varies, and diagnosis is commonly challenging. Although ultrasound is helpful in early gestation, this could be unsatisfactory at advanced gestational age. Hence, a high index of suspicion is required in the diagnosis. We present a case of secondary abdominal pregnancy in a 27-year-old gravida 2 para 0 + 1 at an estimated gestational age of 33 weeks and 5 days. She had ultrasound scan done at 9 weeks and 2 days confirming the diagnosis, but declined surgery to seek spiritual intervention. She subsequently presented with generalized abdominal pain and fainting attack. She had exploratory laparotomy with delivery of a live female baby with no congenital anomaly. The placenta was attached to the left infundibulopelvic ligament and was delivered wholly without remnants. She was discharged on the 8<sup>th</sup> postoperative day, and the baby was discharged after 14 days from the neonatal intensive care unit. Accurate diagnosis and prompt intervention with evaluation of placenta attachment is vital to prevent adverse consequences.

**Keywords:** Abdominal pregnancy, ectopic gestation, placenta

## INTRODUCTION

Abdominal pregnancy is a rare type of ectopic pregnancy, with reported incidence ranging between 1:10,000 and 1:30,000 pregnancies.<sup>1</sup> Primary abdominal pregnancy which is extremely rare occurs when a fertilized ovum implants itself initially on some abdominal organ, whereas secondary abdominal pregnancy occurs when the ovum first implants in the fallopian tube, ovary, or uterus and subsequently escapes through a rupture into the peritoneal cavity.<sup>2</sup> There are few reported cases of abdominal pregnancy developing to term with delivery of a live fetus through an abdominal incision.<sup>3</sup> This is often associated with a significant risk of maternal intraperitoneal hemorrhage from placental separation and adverse consequences. The overall fetal survival rate remains low.<sup>4</sup>

Here, we present a case of abdominal pregnancy with delivery of a normal live baby at an estimated gestational age of 33 weeks and 5 days.

## CASE REPORT

A 27-year-old female, unbooked gravida 2 para 0 + 1 (previous salpingectomy). was referred to our health facility on account

of ultrasound diagnosis of abdominal pregnancy at an estimated gestational age of 33 weeks and 5 days. Her history dated back to 6 months prior to presentation when she started having scanty bleeding per vaginam and slight abdominal pain after two missed periods. She presented to a traditional birth attendant (TBA) who sent her for a pelvic ultrasound scan. The ultrasound scan revealed an intra-abdominal pregnancy at an estimated gestational age of 9 weeks and 2 days. She was subsequently referred to a hospital for surgical management, but she decided to seek spiritual help from a traditional healer. The patient was not desirous of surgical intervention for the index ectopic pregnancy due to fear that it would jeopardize her future fertility potential.

Bleeding later subsided, and she continued her pregnancy care with the TBA until about 24 h prior to presentation when she

**Address for correspondence:** Dr. Oluwaseyi Isaiah Odelola,  
Department of Obstetrics and Gynaecology, Olabisi Onabanjo University  
Teaching Hospital, Sagamu, Ogun State, Nigeria.  
E-mail: seyodelola@yahoo.com

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started having severe generalized abdominal pain and fainting spells. The patient had a total of six ultrasound scans during the pregnancy which all revealed abdominal pregnancy.

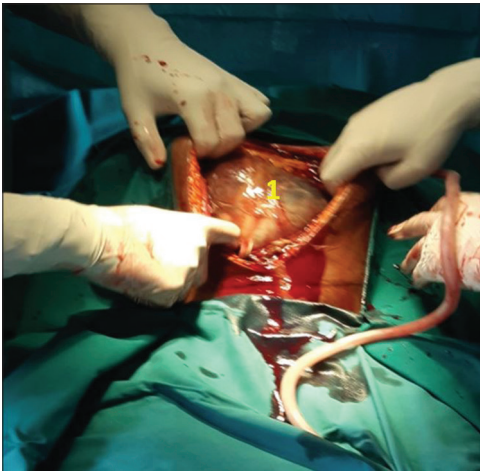
On examination, she was severely pale; her pulse rate was 124 beats/min and blood pressure was 90/50 mmHg. Her abdomen was asymmetrically enlarged, and she had a well-healed Pfannenstiel scar. There was mild generalized tenderness, the symphysis-fundal height was 35 cm, and the baby was palpated to be in an oblique position in the maternal abdomen with the head in the left hypochondrial region and breech toward the right iliac fossa. The fetal heart rate was 142 beats/min. Vaginal examination revealed that the cervical os was closed and the pouch of Douglas was full.

Urgent packed cell volume (PCV) was 18%, and four units of blood were cross-matched. The patient had emergency exploratory laparotomy. A gastrointestinal surgeon and a neonatologist were present at surgery. Intraoperative findings were as follows: hemoperitoneum of about 1 L with clotted blood of almost 500 g; intraperitoneal gestational sac that was flimsily attached to the omentum [Figure 1];

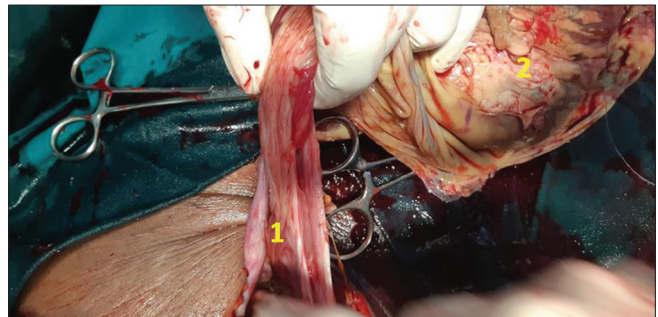
clear-colored amniotic fluid of about 500 mL; a live female baby weighing 2.2 kg with APGAR scores of 4 at 1 and 7 at 5, the placenta was attached with a broad stalk to the left infundibulopelvic ligament, broad ligament, and also the left tube [Figures 2 and 3]; amputated right tube; atretic left ovary; grossly normal right ovary, and bulky uterus corresponding to about 16 weeks' size [Figure 4]. The fetus was delivered and showed no structural abnormality. The thick band connecting the placenta and infundibulopelvic ligament was clamped, ligated, and transfixed with vicryl 1 suture. The placenta was wholly delivered without any remnant left *in situ*. Abdominal drains were inserted into the left paracolic gutter and the pouch of Douglas. The patient had four units of blood transfused perioperatively, and posttransfusion PCV was 27%. The abdominal drains were removed on the 4<sup>th</sup> postoperative day.

The patient was counseled on the intraoperative findings and the need to present early whenever she missed her period. She was discharged on the 7<sup>th</sup> day postoperatively. The patient had three follow-up visits at 1 week, 3 weeks, and 6 weeks postdischarge and was clinically stable.

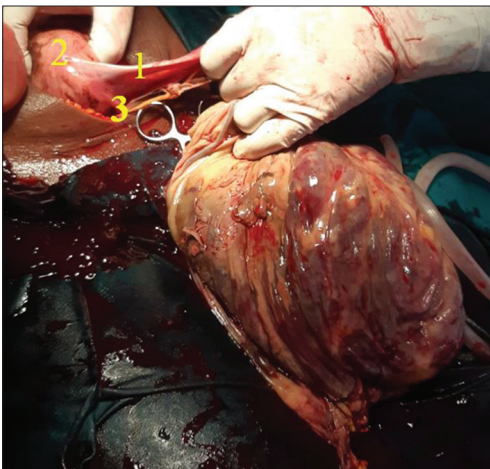
The baby was admitted immediately to the neonatal intensive care unit for incubator care and prophylactic phototherapy. She had exchange blood transfusion done on account of PCV of 25%. She had good recovery and was discharged after 14 days on admission.



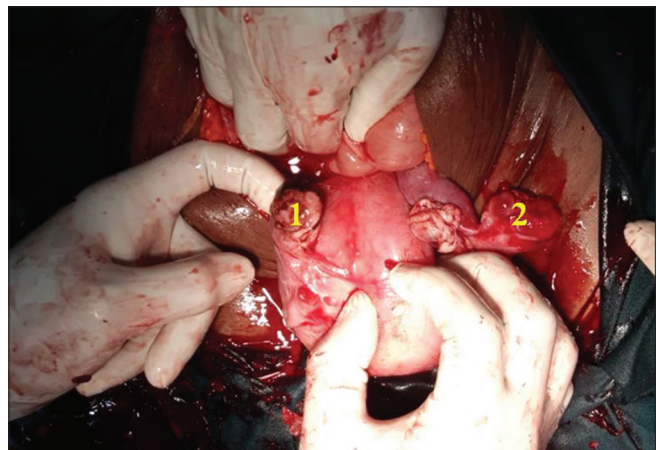
**Figure 1:** 1. Amniotic membrane



**Figure 2:** 1. Infundibulopelvic ligament 2. Placenta



**Figure 3:** 1. Left fallopian tube 2. Uterus 3. Left round ligament



**Figure 4:** 1. Amputated right fallopian tube 2. Left fallopian tube

## DISCUSSION

We presented a case of abdominal pregnancy with delivery of a viable baby. This patient presented with the clinical triad of amenorrhea, abdominal pain, and bleeding per vaginam, which suggested an early pregnancy complication. As presented in this case, ultrasound scan is useful for early diagnosis;<sup>5</sup> however, it may not accurately diagnose late gestational abdominal pregnancy.<sup>1</sup> Magnetic resonance imaging and computed tomography scan may be indicated to diagnose late abdominal pregnancies.<sup>1,6</sup>

This case may be considered secondary abdominal pregnancy because the presentation did not meet the Studdiford's criteria.<sup>7</sup> Although the diagnosis was made early and there was no evidence of uteroperitoneal fistula, the left ovary was atretic as the placenta had taken over the left ovarian vascular bundle passing through the infundibulopelvic ligament.

Abdominal pregnancy is often associated with congenital malformations in about 40% of cases;<sup>8</sup> but in this case, the neonate had no structural deformities. Fifty percent of perinatal mortality rates have been reported among fetuses delivered with congenital anomaly.<sup>9,10</sup>

The management of abdominal pregnancy depends on the estimated gestational age at presentation and the clinical presentation.<sup>10</sup> Preivable gestations require immediate laparotomy irrespective of the clinical status. However, for asymptomatic viable pregnancy, hospital-based conservative management is advocated till lung maturity is achieved. As presented in this case, symptoms such as bleeding per vaginam, generalized abdominal pain, evidence of hemoperitoneum, and worsening vital signs require urgent operative intervention.<sup>9,10</sup> The most serious complication of abdominal pregnancy is bleeding from the placental site. In this case, the placenta was mainly attached to the infundibulopelvic ligament and the adjacent broad ligament, making it easy to deliver by clamping the ligament. However, because of the torrential hemorrhage that could accompany the placenta removal, decisions such as clamping the cord close to the placenta and administration of methotrexate to hasten autolysis and degeneration of the placenta may sometimes be necessary.<sup>5</sup> This intervention may, however, be complicated by intraperitoneal infection and adhesions.<sup>8,9</sup>

Despite the good outcome of this case, it is important to appreciate the fact that advanced abdominal pregnancy could potentially lead to devastating consequences.

## CONCLUSION

Abdominal pregnancy with a viable fetus is a rare occurrence. Early diagnosis and prompt intervention are important in preventing the adverse outcome associated with the condition.

## Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

## Conflicts of interest

There are no conflicts of interest.

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