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Case Report

Intra-Abdominal Ectopic Pregnancy, A Diagnostic Dilemma

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Abstract

Background: Ectopic pregnancy in general and intra-abdominal in particular is more common in the developing countries as compared to the developed countries.

Material and Methods: We describe a rare case of intra-abdominal ectopic pregnancy and the need to have a high level of suspicion for this condition.

Results: In this case we were able to prove that the primary intra-abdominal ectopic pregnancy can be an on table diagnosis, in a patient with severe abdominal pain with fetal parts palpable abdominally.

Conclusion: Excessive instrumentation and assisted vaginal deliveries in the developing world greatly increase the risk of ectopic pregnancy. Also, the clinical presentation of primary intra-abdominal pregnancy varies.

Keywords: *Intra-abdominal; Ectopic; Pregnancy*

Background

Intra-abdominal pregnancies are very rare to occur. Ectopic pregnancy in general and intra-abdominal in particular is more common in the developing countries as compared to the developed countries [1].

Case

The patient was a 28-year-old Indian woman, gravida-3, para-1 with a history of two cesarean sections. The first was done 4 years ago, which was attributed to umbilical cord around the baby's neck. The second was performed 2 years ago and was a lower segment repeat

cesarean section. The woman came to our hospital with a complaint of severe, continuous, non-radiating, diffuse, stretch-like abdominal pain over the past day. There was scant vaginal bleeding and fetal parts were palpable on abdominal examination, which led us to suspect an abdominal pregnancy. Due to irregular periods, she was unaware of her last menstrual period. Her urine pregnancy test was positive. Her vitals were as follows: blood pressure 90/60 mmHg and pulse rate 120 bpm, spO_2 93%. Laboratory parameters were normal except for a hemoglobin concentration of 7.0 g/dL.

In the emergency setting, 6 L/min of oxygen was given by Hudson mask, two wide bore intravenous lines were secured via her forearms, colloids were administered and one bag of packed red blood cells was given rapidly. Laparoscopy was started when her blood pressure dropped to 85/60 mmHg and her pulse rate increased to 110 bpm. A diagnosis of an intra-abdominal ectopic pregnancy was given during the procedure. An emergency USG was also done which revealed diffuse free intraperitoneal fluid around the ectopic fetus near the right abdominal wall and small bowel loops (Figure 1). A moderate amount of intra-abdominal serohemorrhagic fluid was evident. The placenta was attached tightly to the mesentery of the colon and loosely adhered to the right abdominal sidewall. The fetus, suspected to be of 18 weeks gestational age, localized at the right side of the abdomen, and connected to the placenta by a chord was non-viable and without cardiac activity (Figure 2). The placenta and fetus were dissected away completely and safely from the mesentery of colon and the right abdominal sidewall (Figure 3). The uterus and both ovaries were conserved. After closure of the abdominal wall, dilatation and curettage were also performed, but no trophoblastic tissue was found in the uterine cavity. Two units of packed red blood cells were given during operation, and one was administered postoperatively. The patient was awakened, extubated and subsequently discharged.

Figure 1: *USG showing diffuse free intraperitoneal fluid seen around the ectopic fetus near the right abdominal wall and small bowel loops.*

Figure 2: *Fetus in the abdomen and bowels.*

Figure 3: *Fetus and placenta after removal.*

Discussion

Intra-abdominal pregnancies represent 1.4% of all ectopic pregnancies [1]. The majority are secondary to undetected ruptured ectopic pregnancy. According to literature, primary intra-abdominal pregnancy is extremely rare [2]. Recently there has been an increase in instrumentation and assisted vaginal deliveries in the developing world. These factors greatly increase the risk of ectopic pregnancy. The clinical presentation of primary intra-abdominal pregnancy varies. As was seen in our case, one of the most common findings is severe lower abdominal pain [3]. Similar to successful laparoscopic treatment of the ectopic tubal gestation in heterotopic pregnancies, our case, for the first time, exemplifies the safety and efficacy of laparoscopic removal of an intra-abdominal pregnancy without harm to the concomitant intrauterine component, even in a hemodynamically unstable patient.

Conclusion

Excessive instrumentation and assisted vaginal deliveries in the developing world greatly increase the risk of ectopic pregnancy. Also, the clinical presentation of primary intra-abdominal pregnancy varies.

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Conflict of Interest and Funding

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