Abdominal pregnancy with a live fetus – a case report
Gravidez abdominal evolutiva – um caso clínico

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Abstract

Abdominal pregnancy is a rare condition defined by the implantation of the embryo in the peritoneal cavity, exclusive of tubal, ovarian or intraligamentary pregnancy. It is a rare event with high maternal morbidity and mortality. The authors report the case of a secondary abdominal pregnancy with a live fetus at 10 weeks of pregnancy.

Keywords: Abdominal pregnancy; Ectopic pregnancy.

INTRODUCTION

Ectopic pregnancy occurs when the embryo implants outside the endometrial cavity. The most common implantation site is the fallopian tube (98%). Less frequent sites of implantation are the ovary, cervix, cesarean section scar, abdominal cavity and interstitial portion of the fallopian tube¹.

Abdominal pregnancy (AP) is a rare obstetric condition, occurring in only 1% of ectopic pregnancies, and it has a reported incidence of 1:10000 to 1:30000 pregnancies². Abdominal pregnancies are further classified as primary or secondary, with the latter being the most common type. Risk factors for AP are the same as for other types of ectopic pregnancy: previous ectopic pregnancy, smoking, history of sexually transmitted diseases, prior pelvic infection, spontaneous abortion, advanced maternal age, assisted reproduction techniques and intra-uterine device¹.

The access to medical care and the generalized use of ultrasonography have allowed the early diagnosis of these pregnancies, avoiding the serious risks it represents to the pregnant woman. Yet there are cases of late diagnosis of AP, which pose a risk of maternal and fetal morbidity and mortality. Reported maternal mortality rate is 0.5-8% and the perinatal mortality, 40-95%³.

The authors report a case of a secondary abdominal pregnancy diagnosed at 10 weeks.

Thirty-six-year-old caucasian woman, healthy, with a previous right salpingectomy due to a tubal pregnancy, gravida 2, para 0, reporting a 11 weeks amenorrhea, complained of intermittent vaginal bleeding.

When she reached the obstetrics emergency service, pallor and dehydration were observed, but the vital signs were stable. She had a scant hematic vaginal discharge and she mentioned pain on bimanual examination, no masses were palpated. On the ultrasound, the uterus had a regular endometrial lining with an empty endometrial cavity and there was a moderate hemoperitoneum and blood clots on the pouch of Douglas. A live 32mm embryo was identified in the pouch of Douglas (Figures 1 and 2), with no identifiable myometrium seen around it. One normal appearing ovary was clearly identified on the ultrasonography. Hemoglobin was 9.8g/L (normocytic, normochromic anemia), platelets and coagulation profile were within normal limits.

An emergent laparotomy was performed. During the surgery, an abundant hemoperitoneum was present. Uterus was of normal size and the right fallopian tube was not identified (previous salpingectomy), on the left tube, a placenta was attached to its distal extremity with an embryo floating on the pouch of Douglas. A left salpingectomy (Figures 3 and 4) was performed. During the procedure, the patient needed blood transfusions due to a severe anemia (hemoglobin = 5.4g/L). There were no complications on the post-surgery recovery. The patient was discharged two days later.
Histopathological examination confirmed the diagnosis of tubal ruptured ectopic pregnancy.

**DISCUSSION**

Abdominal ectopic pregnancy is classified as primary, when the blastocyst implants directly in the peritoneal cavity. Primary abdominal pregnancy is very rare. Studdiford established three criteria for the diagnosis of primary peritoneal pregnancy: (1) normal bilateral fallopian tubes and ovaries, (2) the absence of uteroperitoneal fistula and (3) a pregnancy related exclusively to the peritoneal surface, early enough to discard the possibility of secondary implantation. Secondary abdominal pregnancies occur when the blastocyst implants in the fallopian tube, ovary or uterus and, following rupture, the embryo or fetus continues to grow in the abdominal cavity. The most frequent type of EP is secondary to a previous tubal pregnancy.

The reported case suggests a primary tubal pregnancy which progressed to an abdominal pregnancy due to the rupture of the tube. The embryo survived in the pouch of Douglas and fetal heart frequency was still positive until the surgery was performed.

The clinical presentation apparently with no abdominal pain is rare, particularly if taken in consideration the large hemoperitoneum. In secondary EP, since they are a consequence of the rupture of a tubal pregnancy, there may be an history of spotting and irregular bleeding, with abdominal pain. Other symptoms of EP are gastro-intestinal symptoms such as nausea, vomiting, flatulence or constipation. Advanced pregnancy may present with fetal malpresentation, cervix displace-
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The main maternal complication was the anemia, needing blood transfusion, one of the well-known complications of this pregnancy described in medical literature. In this case, rapid surgery avoided maternal death due to hemorrhagic shock.

Abdominal pregnancy is a rare condition but in the presence of atypical complains in a pregnant woman there should be a high suspicion for pregnancy complications as this one. The precocious and adequate treatment make the difference on maternal outcomes.

REFERENCES

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