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Case Report Open Access

Antepartum Hemorrhage as Unusual Presentation of Advanced Abdominal Pregnancy

Temesgen Tilahun Bekabil[1*] **and Urgessa Soressa Geleta**[2]

[1]*Obstetrician and Gynecologist, Collage of Medical and Health Sciences, Wollega University, Wollega, Ethiopia*

[2]*Emergency Obstetrics/Gynecology and Emergency General Surgery, Mettu Karl Hospital, Mettu, Ethiopia*

***Corresponding author:** Temesgen Tilahun Bekabil, Collage of Medical and Health Sciences, Wollega University, Wollega, Ethiopia, Tel: +251912057186; E-mail: ttamuko@yahoo.com

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Abstract

Abdominal pregnancy carries higher maternal morbidity and mortality both in developed and developing countries particularly in resource limited settings. Its diagnosis is usually missed during antenatal care despite the routine use of abdominal ultrasonography. This case is presented to show that antepartum haemorrhage, one of antenatal complications of intrauterine pregnancy, can be the presenting clinical condition in advanced abdominal pregnancy and to demonstrate the continuing difficulty in diagnosing this rare but serious condition despite advances in obstetric care. The case also demonstrates how management of advanced abdominal pregnancy, particularly delivery of placenta, is difficult. In conclusion, it is important to have high index of suspicion of advanced abdominal pregnancy when antepartum haemorrhage is presented with other clinical clues of abdominal pregnancy due to the fact that making preoperative diagnosis of this form of pregnancy helps the managing team to be ready for grave complications of abdominal pregnancy at laparotomy and subsequently.

Keywords: Abdominal pregnancy; Advanced abdominal pregnancy; Antepartum haemorrhage

Introduction

Abdominal pregnancy refers to a pregnancy that has implanted in the peritoneal cavity, external to the uterine cavity and fallopian tubes [1,2]. The placenta is often attached to multiple sites, including bowel, omentum, uterine cul-de-sac, and pelvic sidewall [3,4]. The estimated incidence is 1 per 10,000 births and 1.4% of ectopic pregnancies [2,3]. It is associated with very high maternal morbidity and mortality, with the risk for death 7 to 8 times greater than from tubal ectopic pregnancy and 90 times greater than from intrauterine pregnancy, and with perinatal mortality ranging between 40 and 95% [4,5].

Abdominal pregnancy can cause problems at any gestational age but it can go beyond 20 weeks, advanced abdominal pregnancy, which is more often related the above complications [6,7].

Due to its atypical presentation, advanced abdominal pregnancy creates dilemma for the managing obstetrician [7] and its diagnosis is usually missed during antenatal care, despite the routine use of abdominal ultrasonography [6]. Because of this fact, the diagnosis requires a high index of suspicion, and this should be triggered by any of a number of symptoms and signs previously reported in many cases of advanced abdominal pregnancy [8].

The clinical presentations of advanced abdominal pregnancy are so atypical that the diagnosis is often missed. Due to its rarity and vague nature, case reports on abdominal pregnancy are still vital to improve physicians approach in the diagnosis and management of this condition.

To the best of our knowledge there was no reported case of advanced abdominal pregnancy presented with antepartum haemorrhage. Therefore this case will help care providers and researchers to be familiar with the diverse and atypical nature of clinical presentations of advanced abdominal pregnancy.

Case Presentation

A 28 years old gravid II Para I (alive) mother who doesn't remember her last normal menstrual period (LNMP) but claims to be amenorrhic for the last 9 months and 2 weeks presented to Mettu Karl hospital with vaginal bleeding of 4 days. The bleeding was dark-red, non-clotting, moderate in amount and was intermittent. She denied history of bleeding from other body parts. Her antenatal care was in this hospital. During initial visit, urine beta human chorionic gonadotropin (βhCG) test was positive. Her blood group is A+. She had also ultrasound examination at 19 weeks and told to have normal intrauterine pregnancy. Nuchal Translucency was not measured.

She didn't notice fetal movement for the last 2 months and she was also having on and off type of abdominal pain but she didn't visit health institution.

Her previous delivery was at health center and it was uneventful vaginal delivery. She is known HIV positive mother and is on treatment since the last 5 years. She was also treated for tuberculosis a year back. This pregnancy was not planned.

On examination, her vital signs were within the normal ranges and the conjunctiva was pink. Noticeable abdominal findings were 32 weeks sized abdomino-pelivic mass with easily palpable fetal parts, transverse lie and there was mild abdominal tenderness. Fetal heart beat was negative. On genitourinary system exam there was dried blood on vulva but she was not actively bleeding. With the impression of intrauterine fetal death and antepartum haemorrhage she was admitted to labor ward. In the ward, ultrasound examination was done with findings of negative fetal heart beat, femur length corresponding

to 31 weeks and 4 days, no measurable amniotic fluid and calcified mass next to the fetus which seems organized. After filling the bladder with saline and upon rescanning, empty uterus with fetus next to it was seen. With the impression of abdominal pregnancy and to rule out uterine malformation, the patient was investigated and informed about her diagnosis with the possible management plans. Her hemoglobin was 10.9 g/dl. Two units of blood were prepared.

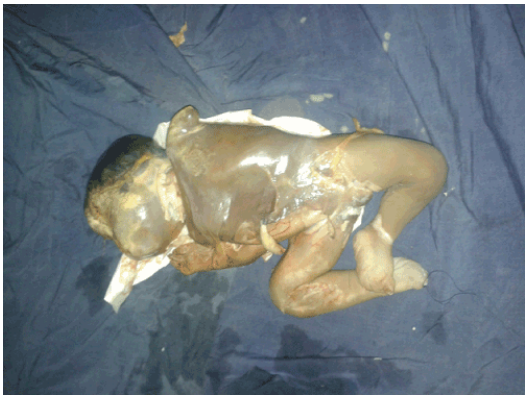

Figure 1: Dead fetus extracted from abdominal cavity at Mettu Karl Hospital, South west Ethiopia, June 2014

Laparotomy was done and the diagnosis of abdominal pregnancy confirmed with intraoperative findings of empty uterus, dead fetus in the abdomen, calcified placenta implanted partly to omentum and partly to parenchyma of right ovary forming adhesion with right tube. The dead fetus weighing 1500 grams was extracted (Figure 1) but placental delivery was difficult requiring right side salpingo-ophorectomy as it was implanted to parenchyma of the ovary (Figure 2). Haemostasis was secured with ligation of visible bleeders and packing. The left ovary and tube are embedded in adhesion.

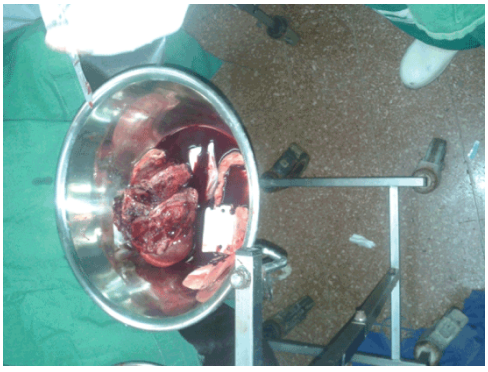

Figure 2: Placenta of abdominal pregnancy implanted into substance of ovary at Mettu Karl Hospital, South west Ethiopia, June 2014

After transferring to the ward, the patient was transfused with two units of blood. She was discharged on 6th postoperative day in good condition.

Discussion

Despite advances in obstetrics cares, there are continuing difficulties in making the diagnosis of abdominal pregnancy [3] as demonstrated by this case. This might be because of atypical presentations of abdominal pregnancy, particularly advanced abdominal pregnancy. Only 42.9%-50% of the patients had preoperative diagnosis based on ultrasound examination [5,7,9]. This might be solved by having high index of suspicion for patients presented with some clues and also advocating routine midtrimester ultrasound scanning by an expert [3].

Our patient presented with cessation of fetal movement, vaginal bleeding and abnormal fetal presentation. It is vivid that abdominal pain, amenorrhea and vaginal bleeding are the triads of early ectopic pregnancies. But what is very striking in this particular mother was the antepartum haemorrhage (APH) she was having. Though, we usually think of placental causes, local and some systemic factors as causes of antepartum haemorrhage, physician can consider advanced abdominal pregnancy in differential diagnosis of patients presented with APH especially when there are other clues and/or risk factors for ectopic pregnancy as in this patient. The APH in patients with advanced abdominal pregnancy might be explained by the endometrial response to hormonal changes during pregnancy [2].

The management of the placenta in an abdominal pregnancy is still controversial. Partial removal of the placenta may result in massive uncontrolled hemorrhage due to lack of uterine contraction unlike normal intrauterine pregnancy. Complete removal of the placenta should be done only when the blood supply can be identified and careful ligation performed [6,10]. In our case the placenta was adherent to the parenchyma of right ovary. Even though leaving the placenta in situ is one option, we did right side salpingoophorectomy due to ongoing bleeding from placental attachment sites.

It is obvious that advanced abdominal pregnancy is related with high perinatal morbidity and mortality [2,3]. About 20% to 40% of babies born after abdominal pregnancy have birth defects, presumably due to compression of the fetus in the absence or decreased amount of the amniotic fluid [4,6]. In our case the outcome was dead fetus with no left upper extremity.

Conclusion

This case study has its own limitation due to the fact that it was reported from resource limited setting where its management, unlike the clinical presentations, might be compromised. In conclusion, antepartum haemorrhage can be one of unusual clinical presentations of advanced abdominal pregnancy. Therefore, it is important to have high index of suspicion of advanced abdominal pregnancy when antepartum haemorrhage is presented with other clinical clues of abdominal pregnancy due to the fact that making preoperative diagnosis of this form of pregnancy helps the managing team to be ready for grave complications of abdominal pregnancy at laparotomy and subsequently.

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