

Late abdominal pregnancy: expectant management with survival of the infant

M. Ravera, E. Cocozza

Hoima Hospital, Regional Teaching Hospital, Uganda

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Introduction

Abdominal pregnancy is a serious obstetrical problem for mother and baby. The reported survival rate of live-born infants of 30 or more weeks gestation is around 60%. The maternal mortality rate, instead, is reported to have decreased from 18.2% in the last century to the present 4.5% [1].

It is said to be rare in the western world where it is often unsuspected or diagnosed late being such an unusual form of ectopic gestation. The pathogenesis remains an enigma although the majority of western cases reported in the literature were related to in-vitro fertilisation and embryo transfer techniques or ovulation induction with human gonadotrophin [2-3].

As a matter of fact abdominal pregnancies occur mainly in developing countries especially as a result of pelvic inflammatory diseases (PID) and the presence of favourable factors such as a low socio-economic and cultural status.

The reported incidence varies from 1/21,439 deliveries in a Maternity and Neonatology centre in Tunisia [4] to the quite high 1/4,017 in an Obstetrics and Gynecology Department in Turkey [5] but in most cases it is simply unknown. In the latter a case of abdominal pregnancy ending in a live birth is described.

A 27-year-old primigravida was referred to our hospital from an antenatal-clinic for obstetrical ultrasound examination due to failure to palpate the uterus although the pregnancy was advanced (~ 30 weeks). She was asymptomatic at her first visit during pregnancy. Ultrasound examination showed an intra abdominal pregnancy with the placenta attached to the small bowel and a viable fetus of 28 weeks. The gestational sac was intact and the amniotic fluid was a normal volume and clear at ultrasound.

The results of other investigations were as follows: haemoglobin 10.2 gr./100 dl., white cell count of 5,700 with a normal distribution, fasting glycemia 90 mg./dl, normal urine examination, blood pressure 120/75, and a negative VDRL.

Expectant management under strict hospitalisation was proposed and accepted by the woman. Fetal assessment was performed by serial ultrasound evaluation of growth and amniotic volume. Emergency operative delivery was accomplished at 32 weeks of gestation by the doctor on call at night, as abdominal colics were considered possible signs of complication. Laparotomy confirmed the ultrasonographic diagnosis and did not show any complica-

tions. Gaseous abdominal colic was, most probably, the cause of the discomfort. An adherent placenta to the small gut was found and left in the abdomen for spontaneous absorption.

Both the mother and the infant (male, APGAR score 7/10 and 10/10 at 1' and 5' respectively) are alive and well after a 6-month follow-up.

In our institution, in the last five years, we have had 363 tubal gestations and 2 abdominal pregnancies out of 9244 deliveries (the present case and the case of a 12-week pregnant mother who was submitted to emergency laparotomy due to massive haemoperitoneum).

In our case report the physical signs aroused the suspicion of an abdominal pregnancy that was confirmed by ultrasound.

Most authors do not delay the surgical procedure after the diagnosis, because of the risk for the pregnant woman. Nevertheless, if the condition of the patient permits, and under strict hospitalisation and close monitoring, an attempt at delaying laparotomy with the aim of obtaining fetal maturity is acceptable [2]. Furthermore, incidentally discovered at term or late abdominal gestations ending in live birth are reported in the literature, giving support to a possible expectant management and therefore being in position to offer a therapeutic option to the patient [2, 6]. The observational period of course requires a surgeon in attendance who can act rapidly if deterioration occurs.

As shown by other authors, the placenta can be left in situ and will be reabsorbed spontaneously, if safe placenta detachment is difficult due to stick adhesion with viscera [4-5].

This was the case of our patient in whom spontaneous placenta involution followed in 2 months uneventfully.

The infant did not present any evidence of congenital abnormalities, although more than 20% are expected to have malformations or deformations, and therefore this possibility should be kept in mind during pre and post-natal care [1].

In conclusion, awareness of this condition, especially in developing countries, is important in preventing abdominal pregnancy related to morbidity and mortality. Careful clinical examination coupled with simple investigatory aids such as ultrasound will secure the diagnosis in most cases.

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Address reprint requests to:
 MAURIZIO RAVERA
 Clinica Ostetrica e Ginecologica
 Ospedale di Circolo
 Viale Borri, 57
 21100 Varese (Italy)