AN UNUSUAL CASE OF ABDOMINOCYESIS FOLLOWING EARLY FUNDAL RUPTURE OF UTERUS

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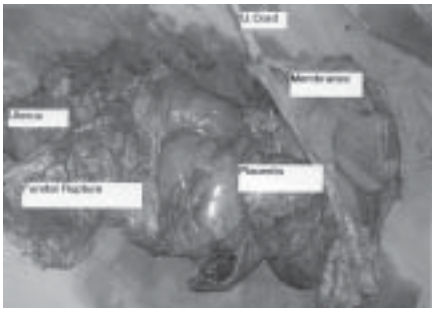
Abstract: *Abdominocyesis is characterized by its morbid pathological process and fetal salvage. In this case, after a is exceedingly rare condition and prolonged period of amenorrhoea, the patient conceived; pregnancy, continued as a secondary abdominal pregnancy after fundal rupture and despite repeated sonology, the condition went undiagnosed. Laparotomy revealed an amniotic sac containing a healthy baby with precarious attachment of placenta and membranes within the peritoneal cavity. Supracervical hysterectomy was performed in view of the wide rupture of the fundus of the uterus. Healthy mother and son were discharged subsequently.*

INTRODUCTION

Existence of primary implantation of fertilized ovum in the peritoneal cavity is questionable. Abdominocyesis is almost always secondary, primary sites being tube, ovary or even an uterine rent. Minor ailments of pregnancy are often exaggerated. Absence of Braxton Hicks contraction and persistent abnormal attitude of fetus should provoke a suspicion. Diagnostic error in sonography may go upto 40%. Hence a clinically conscious provides alead; surest evidence is on laparotomy. Catastrophic hemorrhage and fetal malformation are the primary complications associated with continuation of pregnancy. Ideal surgery involves removing the entire sac-fetus, placenta and membranes. However difficulty encountered often may result in leaving behind the latter two and await aseptic autolysis risking secondary hemorrhage, intestinal obstruction and infection. Maternal mortality with the advances of surgery has been reduced to 5%, but perinatal mortality and morbidity remain as high as 90%.

CASE REPORT

Mrs G.P., a 26year old gravida 2, para1, living issue nil was admitted through the out patient department with amenorrhoea of 9 months duration and clinical as well as radiological diagnosis of transverse lie with central placenta praevia. On examination her pulse was 84/min and blood pressure 130/82mmHg. Previously she was admitted in June 2005 with severe pain abdomen and marked pallor with sonological findings of oligohydramnios. She received 4 units of A+ve blood and was discharged from hospital after conservative management. This was followed by regular antenatal check up. An ultrasound revealed single live intrauterine gestation of 30weeks in transverse lie, placenta completely covering internal os, scanty liquor (Fig.). Her obstetrical history revealed a previous term IUFD with obstructed labor managed by craniotomy subsequent to which she developed a vesico-vaginal fistula that was successfully repaired vaginally 10years back. Subsequently she developed secondary amenorrhoea for 8 long years, treated outside both medically and surgically(D/C); she conceived immediately after the inception of menstruation for the second time. Since her previous antenatal records and previous ultrasound pointed towards term, we decided to go for elective caesarean section with two units of blood in hand keeping the placental position in mind once she started complaining of decreased fetal movements. Laparotomy was done on 16/9/05, which surprisingly revealed intraabdominal gestational sac on incising the parietal peritoneum. Baby was delivered having Apgar score 10 and further exploration revealed an uterus lying low down with ruptured fundus. Placenta was on the internal os anterior and posterior wall of uterine cavity and also on posterior wall of uterus with partial attachment on left broad ligament. Cord had membranous attachment the sac was attached to omentum and transverse colon. Placenta was completely removed, membranes partially without damaging the omentum and gut. Supracervical hysterectomy was performed and a total of 4 units of blood transfused both intra and post operatively. Apart from mild depression of right temporal bone the baby was absolutely normal. Mother and son were discharged on the 8th postoperative day. Follow up at 6 weeks confirmed a normal healthy infant with appropriate milestones and an absolutely healthy mother.



DISCUSSION

Secondary abdominal pregnancy or abdominocyesis is a condition in which the embryo or fetus continues to grow in the abdominal cavity after its expulsion from the tube or other site of its primary development. Incidence is 1 in 3000. Weakening of uterine musculature at fundus possible resulted from previous craniotomy or subsequent D/C. Bladder was relatively free even after repair of VVF. The risk of maternal mortality is 7.7 times greater than tubal pregnancy and 90 times higher than an uterine pregnancy.[1] Recurrent abdominal pain, vomiting in the second and third trimesters, and painful fetal movements are frequent complaints. Often, fetal parts are easily palpated, with the fetus high in the abdomen in a transverse or oblique lie. Anemia is occasionally noted late in the first or second trimester; this is due to intra-abdominal bleeding at the time of partial placental separation as was seen in our case. An unusual lie that does not change over time is also highly suggestive. Misleading ultrasound may be due to stretched omentum over the gestational sac giving the appearance of uterine wall.[2] Fetal abnormalities are seen in 30-95% of survivors and are related to oligohydramnios and to the constricted extrauterine environment, which results in pressure deformities.[3,4] Our baby fortunately survived with minimal deformity.During laparotomy, if the blood supply to the placenta can be safely secured, removal of the placenta completely usually results in good postoperative recovery. In a series of 101 cases, the placenta could be removed completely in 60% and most authors now agree that removal of placenta if straightforward should be the optimal approach. Removal of pelvic organ on which implantation has occurred may be necessary like hysterectomy or salpingo-oophorectomy.[5] Abdominocyesis results in very poor fetal salvage but in our case timely intervention has allowed a very succesful and satisfactory outcome.

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