Abstract:
We report on an abdominal pregnancy that presented as an ectopic pregnancy with right ovarian cyst to our Govt RSRM hospital which actually turned out to be a secondary abdominal pregnancy and review the literature on the management of abdominal pregnancy. The clinical presentation of abdominal pregnancy varies, and the diagnosis requires a high index of suspicion. Ultrasonography is useful for early diagnosis of the condition. The management depends on the gestational age at presentation. The treatment of the placenta is a matter of controversy. In general, expectant management is suggested. In majority placenta gets absorbed. Whether to start methotrexate is also under debate. An awareness of abdominal pregnancy is very important for reducing associated morbidity and mortality.

Keyword: abdominal pregnancy, placenta insitu, methotrexate

INTRODUCTION:
Abdominal pregnancy is a rare variety of ectopic pregnancy. It is defined as an intraperitoneal implantation exclusive of tubal, ovarian or intraligamentous implantation. The worldwide incidence ranges from 1:1320 to 1:10200 births. Abdominal pregnancy is of two types. Primary abdominal pregnancy, when ovum is implanted directly into the peritoneal cavity. Secondary abdominal pregnancy, when pregnancy occurs initially in the tube and later on tubal abortion occurs and fetus gets implanted in the peritoneal cavity. Secondary abdominal pregnancy is more common. This condition is associated with high maternal mortality rates between 0.5% to 18%. The mortality risk from abdominal pregnancy is 7.7-fold that of tubal pregnancy and 90-fold that of intrauterine pregnancy. Maternal morbidity may be due to bleeding, infection, toxaemia, anaemia, disseminated intravascular coagulation, pulmonary embolism, or the formation of a fistula between the amniotic sac and intestine caused by penetration of foetal bone.
CASE REPORT:
This is a case report of a 29 year old primigravida with history of 3 months amenorrhea, who presented to our casualty with complaints of lower abdominal pain and spotting per vaginum of 3 days duration, with sonographic picture suggestive of ectopic pregnancy with right ovarian cyst. On physical examination, the patient was stable except for pallor. Abdominal examination revealed tense, nontender, distended lower abdomen. Per vaginal examination showed cervix pointing downwards, uterus anteverted and bulky. Movement of cervix was not painful and there was no bleeding per vaginum. Urine grav index was positive for pregnancy. Paracentesis and Culdocentesis were positive. Ultrasonogram repeated after admission revealed 7.5x3.5x4cm sized uterus, endometrial lining seen and a small cyst 3x2cm size seen in the right ovary, fluid collection in the Pouch of Douglas and a mixed echogenic mass in Pouch of Douglas. Patient was taken up for Emergency Laparotomy. There was hemoperitoneum of about 100 ml, clot weighing about 100 gms. They were evacuated. Uterus was bulky. Left tube and ovary were normal. Right tube and ovary were densely adherent to the bowel and omentum suggestive of right tubal rupture. Fetus was recovered from the peritoneal cavity and placenta was found in the posterior aspect of uterus adherent to the bowel and omentum. It could not be separated. The cord was ligated and placenta left insitu. Complete hemostasis secured. Abdominal wound was closed in layers. Intraoperatively 1 unit of blood transfused. Post operatively patient was administered 4 doses of METHOTREXATE with FOLINIC ACID. Post operative antibiotics were given for 5 days. Her beta-HCG levels measured on the 18th and 43rd postoperative days were 151 mIU/ml and 3.7 mIU/ml respectively. Follow up ultrasonogram after one month revealed 6x5x8 cm sized echogenic mass with few cystic areas in pouch of Douglas. Colour Doppler showed vascularity with high resistance flow indicating that the placenta has a decreasing blood flow. Complete resorption of placenta may take five months to years. Our patient lost follow up after two months. But the low beta-HCG values in our patient suggests decreasing placental activity.

DISCUSSION:
Management of secondary abdominal pregnancy is difficult, since the placenta will be adherent to the bowel or omentum, any attempt...
to remove it will result in life threatening bleeding. Resection of the bowel and omentum along with placenta is associated with high morbidity. Placental separation is not always straightforward and fails in 40% of cases. So it is best to avoid unnecessary exploration. It is prudent to remove the fetus, tie the cord close to the placenta and close the abdomen. Although no consensus regarding the treatment of the placenta in abdominal pregnancy has been established, most authors advocate leaving the placenta in situ. Some suggest removal of placenta which is associated with considerable risk. Pre-operative arterial embolization has also been advocated by some. We successfully managed without removal of placenta and without significant blood loss. In majority of cases placenta gets absorbed without complications.

The management of the placenta in an abdominal pregnancy is still a matter of debate. Partial removal of the placenta may result in massive uncontrolled haemorrhage and shock. Complete removal of the placenta should be done only when the blood supply can be identified and careful ligation performed. In our case, the placenta was left in situ. This course of action has been recommended for most cases, the cord being ligated in close proximity to the placenta. It has been estimated that the placenta can remain functional for approximately 50 days from the operation, and total regression of placental function is usually complete within 4 months. Although some have reported a five year follow up. Complications may include ileus, peritonitis, abscess formation, bowel obstruction, wound infection, prolonged hospital stay, and fever. Some may need a repeat laparotomy. Some may develop reversible maternal hydronephrosis and prolonged persistent postpartum pre-eclampsia. But the problems associated with retained placenta are less disastrous than an attempt to remove the placenta.

To hasten placental resorption, methotrexate 50 mg/square meter can be used which also has a few complications. In a series of ten cases, accelerated placental destruction led to accumulation of necrotic tissue and abscess formation. It is difficult to attribute this to methotrexate therapy alone, as these complications arise even without administration of methotrexate. Our case did not develop any methotrexate related complication.

In conclusion, although abdominal pregnancy is a rare event, awareness of this condition is very important in reducing the associated morbidity and mortality.

REFERENCES:
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