





Case Report

# Full-term Abdominal Pregnancy with Live Child: About a Case in the Service of Gynecology-Obstetrics at the Ignace Deen National Hospital, Conakry / Guinea

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## Abstract

Abdominal pregnancy is a rare form of ectopic pregnancy, in which the fertilized egg implants and develops in the abdominal cavity. Diagnosis and management are difficult. We report the case of a 31 year-old female accountant referred from a local clinic for abdominal pregnancy in the context of 10 years of primary infertility. Despite the presence of suggestive signs and the number of ultrasounds performed, it was not until the 29th and 31st weeks that the diagnosis of abdominal pregnancy was made. We performed a laparotomy at 37 weeks and extracted a healthy live infant. Fetal extraction led to placental intrusion, the after-effects of which were enamelled with haemorrhagic complications originating from the placenta. These led to a right adnexectomy removing the placenta after an unsuccessful attempt to stop the abundant haemorrhage originating from the placenta. The immediate post-operative course was straightforward, with the patient discharged on the third post-operative day and the newborn well. The importance of this case is to underline the delay in making the diagnosis of abdominal pregnancy in our environment, despite the more frequent use of ultrasound and the possibility of full-term delivery of a healthy child. *Conclusion:* Abdominal pregnancy is a rare event. It is difficult to diagnose, and a conservative attitude to pregnancy is possible.

## Keywords

Abdominal Pregnancy, Maternity Hospital, Ignace Deen

## 1. Introduction

Abdominal pregnancy is a rare event of ectopic pregnancies corresponding to the implantation of the trophoblast in the peritoneal cavity [1]. Advanced abdominal pregnancy (AAP) is classically defined as a pregnancy that has progressed

beyond 20 weeks of gestation during which the fetus is growing and developing within the mother's abdominal cavity, or the fetus shows signs of having been within the mother's abdominal cavity [2]. It affects approximately 1% of ectopic

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pregnancies and its incidence is reported to be 1 in 10,000 to 15,000 live births in Europe [3]. In Africa, the prevalence of abdominal pregnancies varies from one country to another: 1/1134 in South Africa, 1/2583 in Dakar and 1/3750 deliveries in Libreville [1]. It is mainly found in developing countries, which is thought to be due to the high rate of genito-pelvic infections in these countries [4]. This is an extremely rare obstetric complication with high maternal and perinatal mortality. Abdominal pregnancy is characterized by late diagnosis. Clinical examination and ultrasound play a key role in diagnosis. Treatment is always surgical and the fetal prognosis is often very poor [3]. Advanced forms, beyond the fifth month, are more frequent in developing countries. It is responsible for perinatal mortality of between 40 and 95% [2].

In this article, we report a case of an abdominal pregnancy of 37 weeks of amenorrhea observed in the Gynecology-Obstetrics department of the National Ignace Deen University Hospital in Conakry.

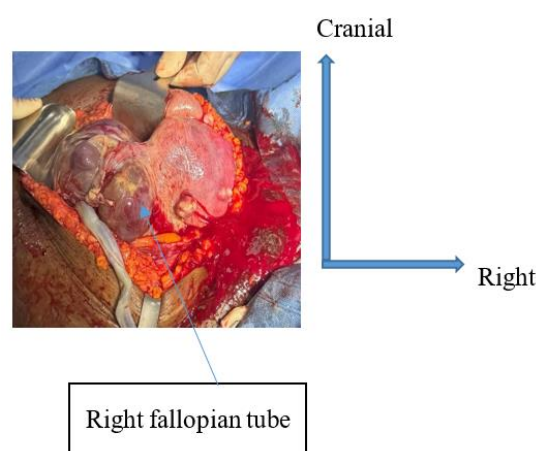
Our objective is to report a case of evolutive abdominal pregnancy at 37 weeks of amenorrhea with a review of the literature.

## 2. Observation

This is a 31-year-old female accountant referred from a local clinic for abdominal pregnancy. She had undergone four prenatal consultations and four (4) obstetric ultrasounds, the first of which at 12 weeks and 1 day concluded to be an unruptured right tubal ectopic pregnancy; a laparotomy was proposed. The absence of clinical signs and the context of infertility caused the patient to disappear. She underwent three ultrasounds at the 29<sup>eme</sup>, 31<sup>eme</sup> week and at 35<sup>eme</sup> week and 2 days having all concluded to an evolving abdominal pregnancy without morphological anomalies and the decision to follow the pregnancy to obtain a term of viability was taken. The gynecological-obstetric history reveals a 10-year history of primary infertility treated with ovulation inducers (clomiphene citrate). On clinical examination, the general condition was good, the conjunctiva and mucous membranes were normal in color, the body mass index was 31.93 kg/m<sup>2</sup> (weight: 88 kg, height: 166 cm). Blood pressure was 149/98 mmHg and the pulse rate was 100 beats/minute. The obstetric examination revealed a shiny abdomen on inspection, palpation of the fetus under the skin, the mobile head above the pubic symphysis. The fetal heart sounds were present and regular at 140 beats per minute. On vaginal examination, the cervix was long, posteriorly closed, and the uterus was of normal size, laterodeviated to the left. The obstetric ultrasound performed on the day of the procedure revealed an evolving singleton abdominal pregnancy whose fetal biometry corresponded to 37 weeks of amenorrhea, with a normal-sized uterus.

Preoperative laboratory assessment revealed mild normochromic normocytic anemia with a hemoglobin level of 10.3 g/dl and normal hemostasis assessment. A midline laparotomy

above and below the umbilical cord was performed under general anesthesia. It revealed macroscopically a clean abdominal cavity, a slightly enlarged uterus, an intra-abdominal amniotic sac from which the amniotomy released clear fluid followed by the cephalic extraction of a live girl, Apgar at the first minute 9/10, at the fifth minute 10/10, weighing 3100 g, length 50 cm and head circumference 33 cm. The placenta was inserted on the right edge of the uterus, the right adnexa and the omentum. Removal of the placenta led to a right adnexectomy after abundant hemorrhage from the placenta. The immediate postoperative course was straightforward and the patient was discharged on the third postoperative day and the newborn was in good health.



**Figure 1.** Uterine fundus.



**Figure 2.** Placenta adhering to the right appendix.



**Figure 3.** Placenta in the abdominal cavity.



*Figure 4. Newborn.*

### 3. Discussion

In our daily practice, abdominal pregnancy remains a rare condition of ectopic pregnancy. We distinguish between early abdominal pregnancy and advanced abdominal pregnancy diagnosed after 20 weeks of amenorrhea (WA) [2]. These advanced forms are mainly observed in countries with low medical density [5]. The incidence of abdominal pregnancies varies depending on the country, 1/10,000–15,000 deliveries in Europe [3]. In Africa, it is less rare and its frequency varies from 0.009% in Morocco to 0.152% in Nigeria. This variability in the incidence of the condition is explained by a lack of early diagnosis of young forms of abdominal pregnancy in developing countries. Indeed, in these countries, pregnancy consultations are late due to the low accessibility (financial and geographical) to the health system but also due to certain morals and customs which mean that women generally do not declare their pregnancies before the 2<sup>th</sup> trimester [3]. On the other hand, in developed countries, the quality of prenatal monitoring and in particular progress in ultrasound allow the early diagnosis of abdominal pregnancies and then indicate the termination of the pregnancy at early stages [6].

This difference is also explained by the high prevalence of sexually transmitted diseases causing tubal lesions frequently observed in Africa [7]. There are two types of abdominal pregnancies related to pathophysiological mechanisms. Secondary abdominal pregnancies, the most frequent, are due to tubo-abdominal abortion, rupture of a tubal pregnancy, or migration of an intrauterine pregnancy through a hysterectomy breach, uterine perforation or a rudimentary horn and primary abdominal pregnancies due to implantation of the egg in the peritoneal cavity by delayed ovular capture [7]. Our case can be classified among primary abdominal pregnancies because it evolved normally until term with an intact uterine body and tubes. Clinical diagnosis is often difficult but a group of signs can direct the diagnosis towards an abdominal pregnancy: digestive disorders, abdomino-pelvic pain concomitant with fetal movements, superficial fetus. Ultrasound plays an important role in the diagnosis of abdominal pregnancy. It highlights the ultrasound signs of abdominal pregnancy: the absence of visualization of the uterine wall between the maternal bladder and the fetus, the location of the

placenta in an extrauterine position, the visualization of the fetal parts close to the maternal abdominal wall, the abnormal presentation of the fetus and the absence of amniotic fluid between the placenta and the fetus [1]. However, ultrasound fetal assessment is often difficult given the frequency of oligohydramnios which hinders morphological examination [8].

In our clinical case, the patient benefited from an early ultrasound from the 12<sup>eme</sup> week plus 1 day which suggested an ectopic pregnancy without determining the location in a context of primary infertility of 10 years, after several counseling sessions on the termination of the pregnancy, it was necessary to wait until the 29<sup>th</sup> week and 31<sup>th</sup> weeks for the diagnosis of abdominal pregnancy to be considered. Serge Robert Nyada et al. in Cameroon reported that, despite the patient having consulted early and having an ultrasound in the first trimester and others after manual intrauterine aspiration, it took until the 25<sup>th</sup> week and the fifth ultrasound for the diagnosis of abdominal pregnancy to be considered [1]. Ultrasound remains the gold standard for diagnosing abdominal pregnancies. However, ultrasound diagnosis of advanced abdominal pregnancies is difficult and is missed in half of cases [4]. Obstetric ultrasound performed as a first-line procedure allows for clinical suspicion, without allowing for a correct analysis of the relationship of the placenta with the abdominal organs [9]. Explorations such as CT and MRI allow, in case of doubt, to confirm the diagnosis and determine the limits of insertion of the placenta and to specify its position in relation to the intra-abdominal viscera, but these examinations are of limited accessibility in our context. In the case of early abdominal pregnancy, laparoscopy is an essential tool with a dual role, both diagnostic and therapeutic. The management of advanced abdominal pregnancy is essentially surgical [10, 11]. Some authors recommend medical termination of the pregnancy once the diagnosis has been made, without consideration of fetal status given the unpredictable and serious nature of maternal complications that can occur at any time [12]. For others, a conservative approach to pregnancy may be proposed up to 34 weeks, in order to obtain fetal lung maturity, at which time a laparotomy will be indicated [13]. This conservative approach can only be carried out subject to the absence of major congenital malformation, a placental insertion site distant from the liver and spleen, maternal clinical stability and close monitoring of the pregnancy in good consultation with the parents informed of the risk. Our clinical case met these criteria. Thus, a laparotomy was indicated at 37<sup>th</sup> week which allowed the cephalic extraction of a live girl, Apgar at the first minute was 9/10 and 10/10 at the fifth minute, weighing 3100 g, height 50 cm and head circumference at 33 cm with decision to leave the placenta after proximal ligation of the cord and allow its spontaneous resorption or add Methotrexate to accelerate it. The fetal extraction resulted in a rupture of the placenta whose immediate consequences were punctuated by abundant hemorrhagic complications from the placenta which led to an

adnexectomy on the right removing the adnexa, the placenta and broad ligament and requiring a transfusion of two red blood cells.

Bleeding from the placental implantation site can be massive if the vessels are not identified and ligated. Removal of the placenta increases the risks of hemorrhage and blood transfusion on the one hand, on the other hand, the conservative approach of leaving the placenta in place carries risks of peritonitis, abscess, intestinal obstruction, re-intervention and prolonged hospitalization [14, 15]. The immediate postoperative course was straightforward and the patient was discharged on the third postoperative day with her newborn in good health. This finding is identical to that of Hounkponou F [16] et al in Benin, who reported that recovery was straightforward for both mother and newborn. In our case, the postoperative course was good with primary surgical healing two weeks after the procedure. Clinical and ultrasound monitoring at 3 months postoperatively was unremarkable and the favorable fetal prognosis was 100% in our series.

## 4. Conclusion

Full-term abdominal pregnancy resulting in a live birth of a healthy infant is a rare event. It occurs mostly in low-income countries. Its recognized difficulty in diagnosis must be diagnosed early, with the contribution of ultrasound, which must be routinely performed during pregnancy. Training of personnel in ultrasound and strict pregnancy monitoring could improve early diagnosis and maternal-fetal prognosis.

## Abbreviations

CHU	University Hospital Center
PAA	Advanced Abdominal Pregnancy
SA	Week of Amenorrhea
IRM	Magnetic Resonance Imaging
Coll	Collaborators

## Author Contributions

**Sow Ibrahima Sory:** Conceptualization, Formal Analysis, Methodology, Writing – original draft

**Fofana Naby:** Conceptualization, Funding acquisition, Resources, Writing – original draft

**Sylla Ibrahima Boffa:** Data curation, Investigation, Supervision

**Diallo Boubacar Alpha:** Project administration, Supervision, Validation, Writing – original draft

## Conflicts of Interest

The authors declare no conflicts of interest.

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