

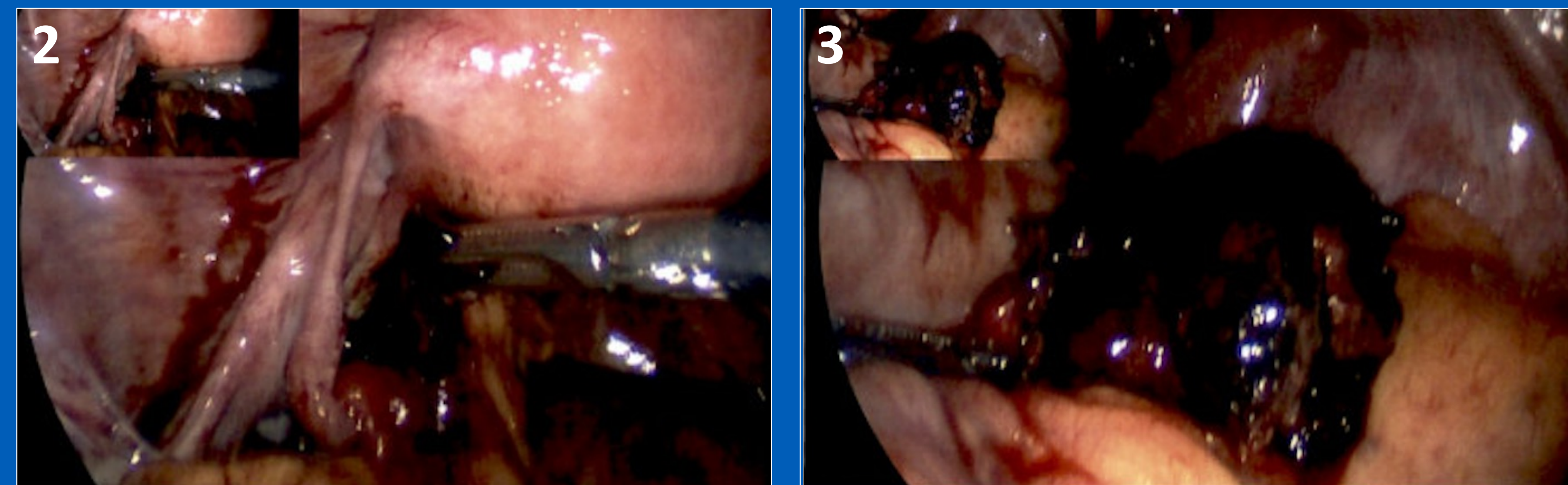
Diagnostic challenges and management considerations of abdominal pregnancies: A case report

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OBJECTIVE

Abdominal pregnancy (AP) is a rare type of extrauterine pregnancy accounting for 1% of ectopic pregnancies¹. AP can be primary - where the blastocyst implants in the abdominal cavity, or secondary – when a pregnancy that was previously located elsewhere implants in the abdomen (ruptured tubal ectopic)². Early diagnosis is necessary to minimise the high morbidity and mortality rates associated with this condition. However, diagnosis is difficult and only 20-40% of cases are diagnosed preoperatively¹. This case details an AP identified intraoperatively and discusses some of the diagnostic challenges to correct diagnosis.



Figures 1, 2 and 3: Demonstrate transvaginal ultrasound images of left ovary and left adnexal mass lateral to the ovary. Intraoperative findings of tortuous left fallopian tube and suspected AP implanted on the left pelvic side wall, separate to the ovary and tube.

CASE REPORT

A para 1 presented to hospital at 6 weeks gestation with spotting. Transvaginal ultrasound demonstrated a left adnexal mass suspicious for ectopic pregnancy (see figure 1). The patient was counselled regarding risks and management options and opted for expectant management as she was asymptomatic and reluctant to undergo any intervention.

At 48-hour follow up, she remained asymptomatic. However, the following day she represented with severe abdominal pain. Ultrasound demonstrated a left adnexal mass with significant haemoperitoneum. She was diagnosed with a ruptured left ectopic and taken for an emergency laparoscopy. Intraoperative findings included 100ml haemoperitoneum, tortuous and bleeding left fallopian tube and an AP implanted in the peritoneal cavity, adjacent to the left pelvic side wall and sigmoid colon (see figures 2 and 3). A left salpingectomy was performed, and the bowel mobilised to remove the AP tissue. Intraoperative blood loss was minimal and the patient's recovery unremarkable.

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DISCUSSION

This case demonstrates the varied presentation of AP. Patients with AP may be asymptomatic, present with minor pregnancy-related symptoms or experience life-threatening intraabdominal haemorrhage². A high index of suspicion is needed as well as accurate imaging to accurately diagnose AP. Ultrasound criteria³ to diagnose early AP has been proposed and could improve rates of preoperative diagnosis. MRI can be used as an adjunct to ultrasound to accurately localise the pregnancy, blood supply and adherence to surrounding tissues⁴.

It is vitally important to diagnose AP early to appropriately counsel patients regarding management options³. With hindsight, expectant management was not appropriate in this case due to the increased risks associated with AP. Furthermore, preoperative diagnosis of AP enables optimisation of surgical management. That is, consideration of the need to transfer patient to a tertiary hospital, access to interventional radiology and availability of appropriate skillset for operative management depending on the AP location⁴.

CONCLUSION

This case demonstrates the difficulty of accurately diagnosing an AP. Despite timely review by an early pregnancy unit and the use of transvaginal ultrasound, the AP was not diagnosed until diagnostic laparoscopy.

Due to the high risk of complications and maternal mortality, APs should be treated surgically as soon as possible.