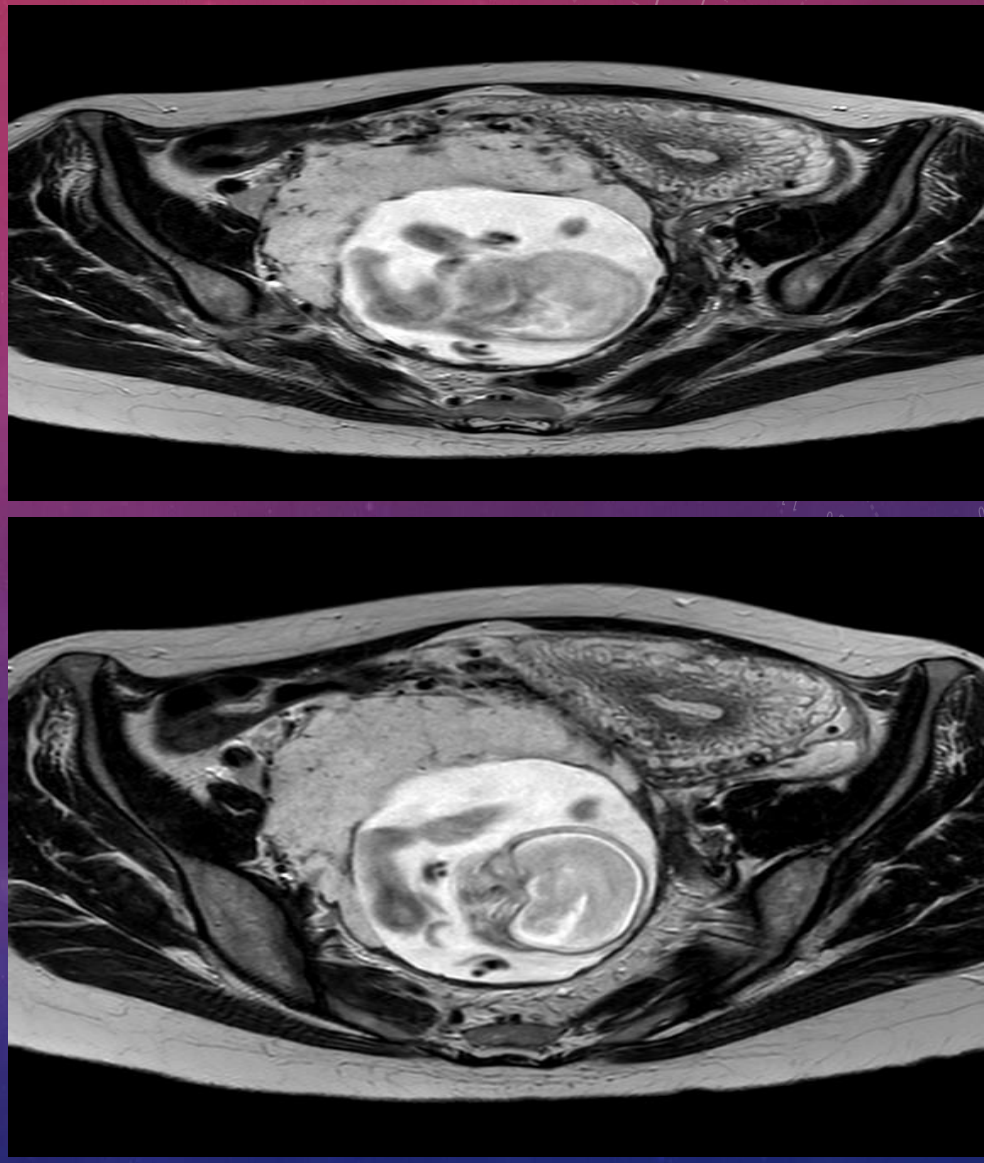
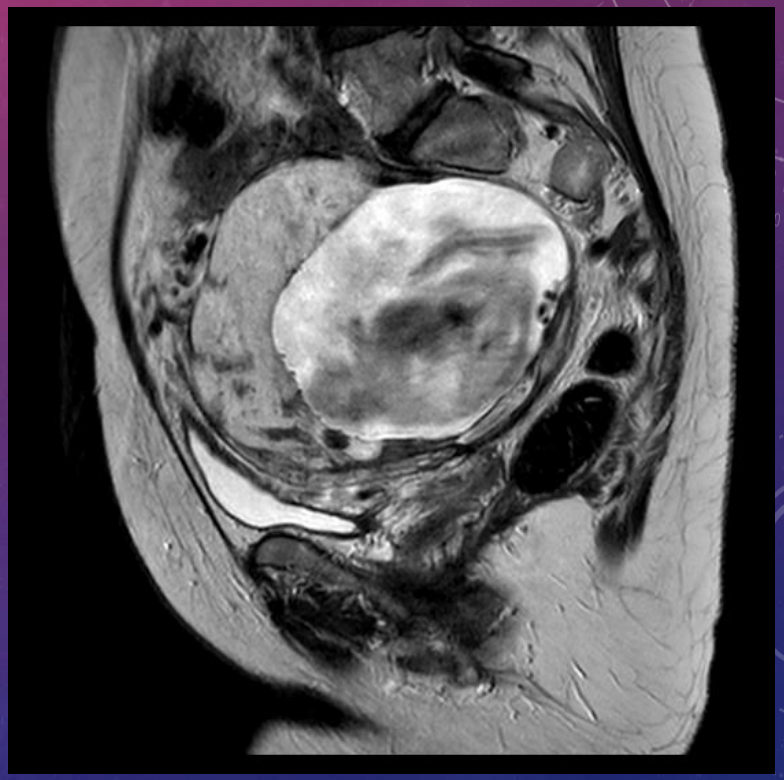
ADVANCED ABDOMINAL PREGNANCY
A CLINICAL CHALLENGE

- Abdominal pregnancies are rare, 9 per 1000 ectopic pregnancies.
- Continuation into the third trimester is rarer still. The reported incidence ranges from 1:10,000 to 1:30,000.
- The risk of dying from abdominal pregnancy is 7.7 times higher than tubal pregnancy and 90 times greater than an intra-uterine pregnancy.
- The maternal mortality may range from 0.5% to18% and perinatal mortality rate is 40–95%.

- We present a case of advanced abdominal ectopic pregnancy.
- A 41 year old woman with secondary infertility, conceived with clomiphene.
- At 7 weeks of gestation she presented with bleeding to our early pregnancy assessment unit (EPAU).
- Ultrasound scan showed cystic vascular area of mixed echogenicity within upper uterine cavity measuring 21x37mm and bHCG was 22218 IU/l
- Surgical evacuation of uterus was performed with an assumption that it might be molar pregnancy
- Histology showed decidua and hypersecretory endometrium but no products of conception.
- Her GP and herself were sent letters advising to perform pregnancy test and if positive to contact EPAU
- She didn't receive the letter, and when she was seen by GP few weeks ago, her pregnancy was still positive

- She had a ultrasound scan in EPAU , which showed extrauterine pregnancy
- MRI Scan confirmed abdominal pregnancy of 18-19 weeks gestation, implanted on right broad ligament, ovarian pedicle extending to the pelvic side wall. Uterus was displaced to left and cavity was empty. There was no communication between gestational sac, placenta and uterine cavity. Placenta was receiving blood supply from the iliac artery and other prominent blood vessels on the right broad ligament
- Consensus from colleagues in the department and other departments were taken to look into the options to offer





- Options discussed

1. Termination of pregnancy

- advised on the basis that if there is any separation of the placenta form iliac artery there is a significant risk of life threatening heamorrhage.
- Hence it is better to manage things at a controlled time with optimal preparation. Ideal to perform before 22 weeks, require laparotomy with midline incision to deliver the baby and tie off the cord close to the placental origin leaving placenta in-situ to naturally involute or to consider methotrexate.
- This is could reduce the risk of massive heamorrhage as the size of placenta was small.
- There could be potential risk of sepsis requiring intravenous broad spectrum antibiotics for few days and the risk of thromboembolic disease

2. Continuation of the pregnancy and elective premature delivery:

- This would maximize chances of baby surviving;
- however there are still risks of sudden and unexpected fetal demise.
- With risk of small for gestational age, the timing of delivery would probably between 28-33 weeks of gestation.
- This would add additional risk of morbidity and mortality due to prematurity.
- The maternal morbidities/ mortalities are associated with extensive surgery with massive uncontrollable heamorrhage might lead to death., due to placental size and spread
- Potential secondary risks of infection/sepsis and thromboembolic disease

- Patient opted for option 2,
- keen to continue with pregnancy
- totally understands the risks to herself and baby.
- Aware of 1in 4 risk of maternal death

REAL CLINICAL CHALLENGE

- To liaise with other departmental colleagues for optimal preparation and to manage the catastrophic condition with minimal adverse effects
- To have strategy and staff availability to prepare and manage in emergency

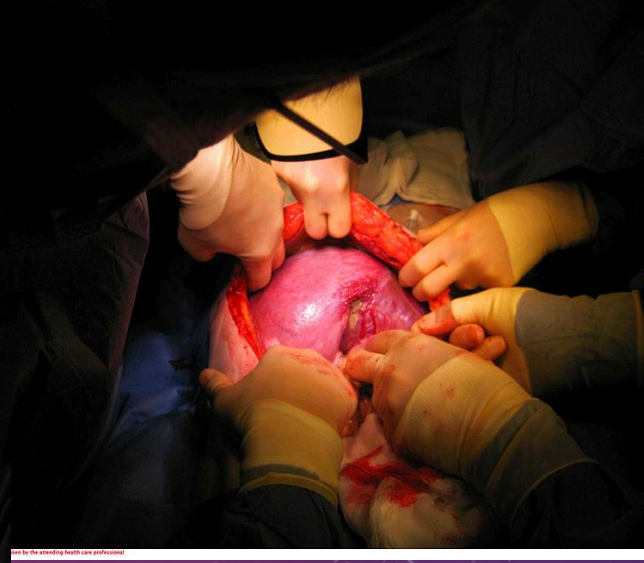
- Aim to deliver at 28-29 weeks in vascular theatre in presence of multidisciplinary team including vascular surgeons, general surgeon, interventional radiologist, haematology consultant, obstetrics anaesthetist along with obstetrician and Gynae-oncologist
- Case discussed with haematology consultant, theatre coordinator and blood transfusion operation manager
- Advised 4-6 units cross match preoperatively, booked perfusionist for cell salvage

- All on call obstetrician and gynaecologist were made aware of this patient with a plan to manage in emergency
- On call vascular team arrangements in emergency if patient presents with any symptoms
- Patient was reviewed in antenatal clinic regularly, seen by CMW in between

- She was admitted 3 weeks before the surgery
- Day before she had Magnesium sulphate to prevent cerebral palsy in preterm babies

- On the day of surgery , there were a team of nine consultants including obstetrician, Gynae oncologist, colorectal surgeon, two vascular surgeons, two obstetric anesthetists, urologist, and interventional radiologist, along with a perfusionist, experienced theatre staff and blood bank was standby during the procedure

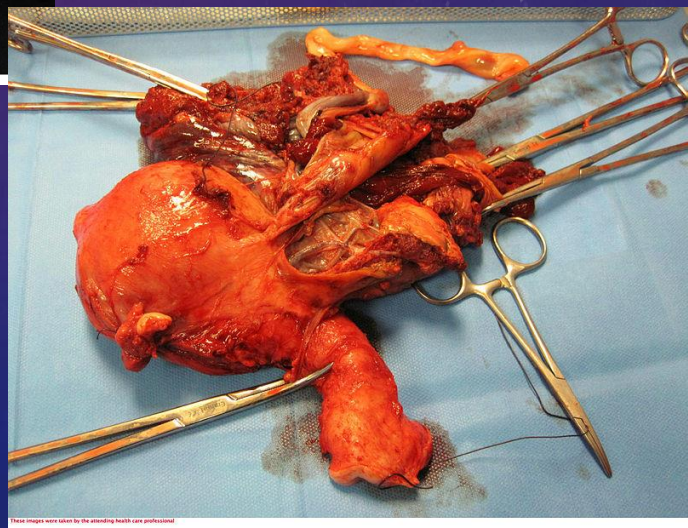
extensive transverse upper abdominal incision was given and extended to left iliac fossa,



There was no plane of membranes to deliver baby

baby has to be delivered through the placenta.

placenta was removed along with uterus, right tube, right ovary, appendix and left tube along with the broad ligaments.



- Right ureter was injured during the procedure, so had urteric re-implantation with a stent in.
- As expected patient had torrential bleeding and received 8 units of red cells, 4 units of fresh Frozen Plasma, 1 unit of platelets, 2 units of cryoprecipitate
- Total blood loss during the surgery was estimated to be 4 litres.

- Patient was transferred to ITU for 24 hrs were observation and later shifted to high dependency care on delivery suite
- Baby was transferred to neonatal unit and discharged after few weeks
- Patient recovered well and discharged home 10 days after surgery
- In 2 weeks she presented with left leg swelling and was diagnosed with ileo-femoral DVT.
- She was reviewed by urologist and stent was removed 6-8 weeks after surgery