CASE REPORT

Secondary Abdominal Pregnancy with Placenta Accrete in Previous two Cesarean Section

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ABSTRACT
BACKGROUND: Extrainuterine abdominal pregnancy is an extremely rare condition and is frequently missed out in routine antenatal care. This is a case report of a full-term live secondary abdominal pregnancy, in a patient with previous two caesarean sections, with placenta previa and accreta who subsequently delivered a healthy baby.

Key words: Abdominal pregnancy, caesarean section, live baby placenta previa, placenta accrete.

INTRODUCTION
A 30 yr old pregnant female was referred to Civil hospital Ahmedabad as a case of G3P2L2 with 71/2 months amennorhoea with previous 2 cesarean sections with central placenta previa with rudimentary horn with pulmonary tuberculosis. Menstrual history: LMP: 6/6/2014 EDD: 13/3/2015. Obstetric history: G3P2A0L2 1st Full term LSCS / Primi breech /3 years 2nd Full term LSCS / Prev.CS NPOL/1year Past history: patient is a known case of pulmonary tuberculosis since 7 months, stopped medication after 1 month All investigation including CBC, LFT, RFT, PT INR were WNL Chest X RAY (with abdominal shield):left upper zone shows fibrocavitary lesion s/o kochs, right upper zone fibrotic lesion noted. USG ANC: Uterus like structure is seen in left lateral side of gravid uterus P/O bicornuate uterus with right gravid horn and left empty horn. A SLIUF with breech presentation with 32 weeks maturity. Placenta: central, low lying and completely covering the os. Liquor: adequate. EFW: 1631 gm USG ANC DOPPLER: Normal.

MANAGEMENT
Pulmonary medicine opinion was taken in view of patient being defaulter of pulmonary koch's. After 2 positive AFB sputum samples patient was started on AKT category II under RNTCP. During her stay in ward patient was monitored closely. Mother was observed for any bleeding per vaginum. Fetal monitoring with daily fetal movement chart and NST was done. Steriods coverage was given for fetal lung maturity. After a month of conservative management, follow up USG Doppler showed 34 weeks maturity with reduced CPR, so electve CS was planned. Intra operatively baby was in abdominal cavity with intact amniotic sac, outside the uterine cavity, complete rupture of previous CS scar was present, placenta was morbidly adherent to lower uterine segment and posterior wall of opened up uterus. Placenta accreta was encountered, and obstetric hysterectomy was done. Intra operatively 2 units of PCV and 1 units of whole blood was given. Post operative period remained uneventful. Patient was...
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DISCUSSION
The incidence of abdominal pregnancy is 1 in 10,000 to 1 in 25,000 live births\(^1\). The maternal mortality rate is 0.5 to 8\%, and perinatal mortality ranges between 40\% and 95\%\(^2\). Abdominal pregnancy is usually complicated and leads to high maternal and perinatal mortality. Misdiagnosis is the main cause of these complications. There is no definitive diagnostic tool for diagnosis of secondary abdominal pregnancy. “High clinical suspicion” is the key for prompt diagnosis and timely intervention to prevent life threatening complications. During surgery, massive intra-abdominal bleeding due to placental separation is unpredictable, therefore regardless of gestational age of pregnancy, surgery should be performed as the diagnosis is confirmed. During surgery, partial removal of placenta can lead to massive bleeding, due to implantation of the placenta over the tissues which cannot contract. In this patient, site of bleeding was stopped by performing obstetric hysterectomy. Early diagnosis depends on the clinician’s suspicion. Bleeding is the single most important life threatening complication, massive haemorrhage from placental separation may cause maternal death. Thus keeping in mind all the possible complications, written and informed consent regarding obstetric hysterectomy should be taken, ventilator support should be sought, and patient should be managed in a tertiary setup with an expert team.

CONCLUSION
In the above case abdominal pregnancy was carried up to term without diagnosis as we received the patient at 3\(^{rd}\) trimester of pregnancy. As advanced abdominal pregnancy is difficult to diagnose, a high index of suspicion is required by the clinician. A clinician should be very vigilant in diagnosing this condition.

REFERENCES