

incision under spinal anesthesia. On opening a peritoneal cavity, a dead fetus was found in the peritoneal cavity with an intact amniotic sac. Uterus was 20 weeks in size, firm and well contracted, and there was no scar dehiscence. Both ovaries and fallopian tubes were morphologically normal. Intraoperative diagnosis of abdominal ectopic pregnancy was made and the decision was made to extend the incision above the umbilicus. While extending the incision, injury to placenta led to massive blood loss. Patient went into severe hypotension. Four units of blood were transfused, general anesthesia was given and the patient was intubated. The incision was extended above the umbilicus. The placenta was found to be attached to the greater omentum. A 2.7 kg, full-term dead, male fetus was delivered. On examination, the fetus had congenital talipes equinovarus and polydactyly. Absence of macerative changes was indicative of a recent fetal death. We were not able to assess the internal anomalies as the mother refused to give consent for an autopsy. Liquor was thick; meconium stained. The placenta was separated from the greater omentum and removed in piecemeal. Peritoneal wash was given with saline and a drain was placed in situ. The abdomen was closed in layers. Patient was given broad spectrum intravenous antibiotics for two days followed by oral antibiotics for five days. Postoperative course was uneventful. Breast milk suppression was done with a dopamine agonist (Cabergoline 0.5 mg 2 tablets stat). Patient was discharged on the seventh day after suture removal. Contraceptive counseling was done.

Discussion

Abdominal pregnancy is a rare form of ectopic pregnancy. It is associated with high maternal morbidity and mortality rate. Morbidity is due to bleeding, infection, toxemia, DIC, anemia and pulmonary embolism. The perinatal mortality rate is 40-95% [2]. Birth defects have been found in about 21% of babies due to compression of the fetus in the absence of amniotic fluid buffer. Typical deformities include facial and cranial asymmetry, limb defects, joint abnormalities and CNS malformations [3]. Several factors have been identified that increase the risk of ectopic pregnancy such as history of pelvic inflammatory disease, chlamydial or gonococcal cervicitis, infertility, morphological tubal abnormality, previous tubal surgery, recent use of Intrauterine Device (IUD) as contraception and history of previous ectopic pregnancy [6].

Ultrasound examination is a versatile and safe imaging modality to diagnose ectopic pregnancy. However, ultrasound facilities are still inaccessible to many who live in remote areas. The hormonal environment in ectopic pregnancy can produce an intrauterine fluid collection that mimics the gestational sac. Visualization of a gestational sac on a transvaginal ultrasound cannot confirm intrauterine pregnancy. Identification of an intrauterine gestational sac with yolk sac on a transvaginal ultrasound during early pregnancy rules out ectopic pregnancy in most patients. This finding should be reinforced by threshold β -hCG level (1000-2000 IU/L with transvaginal approach, 6500 IU/L with transabdominal approach) at which an intrauterine gestational sac can be reliably seen in normal pregnancy [6].

Advanced abdominal pregnancy can pose diagnostic difficulties due to variable clinical presentation. A high index of suspicion is required in making a prompt diagnosis especially in low resource centers [5]. Several clinical features such as persistent abdominal pain, painful fetal movements, palpation of an abdominal mass separate from the uterus, vaginal bleeding, or unattached and posteriorly displaced pinpoint cervical os should raise suspicion [7]. However, our patient did not have any symptoms during her antenatal period

except for abdominal pain, which started at 38 weeks. Ultrasound can be very helpful in earlier stages of pregnancy but can be disappointing in later stages. Absence of a uterine wall surrounding the fetus, fetal parts very close to the abdominal wall and abnormal lie on ultrasound examination should raise suspicion for abdominal ectopic in advanced pregnancy [3]. High maternal serum Alpha-fetoprotein levels and lack of myometrial response to oxytocin stimulation are other tools to help diagnose abdominal pregnancy [8].

Once diagnosed, the widely accepted treatment is immediate laparotomy due to risk of complications. However, controversy exists regarding the use of a conservative approach if pregnancy has been discovered to be in an advanced stage and the fetus is alive. A conservative approach should only be undertaken if the patient can be monitored closely, preferably in hospital [3,7]. Another issue of debate is whether to remove the placenta during laparotomy. Unless the blood