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Research Article

**EVALUATION AND ASSESSMENT OF THE INTRAUTERINE,
HETEROTOPIC AND INTRABDOMINAL AT TERM
PREGNANCY**¹Dr Asma Ashiq, ²Dr Nazish Iqbal, ³Sidra Rahman¹WMO, THQ Haroon Abad, ²WMO, Rural Health Centre Pacca Larran, Khanpur, Rahim Yar Khan, ³Punjab Medical College Faisalabad.**Article Received:** January 2019**Accepted:** February 2019**Published:** March 2019**Abstract:**

Both intrauterine and intrabdominal pregnancy is discussed in this report. The patient was treated at Jinnah Hospital, Lahore in August 2018 with the birth of a dead macerated baby. At laparotomy carried out for the second twin, the abdominal pregnancy was identified. The weight of the female baby who born alive was 1800 grams. After seven days of operation, mother and baby were in normal condition and allowed to go home. Fewer cases have been presented regarding heterotopic pregnancy.

Keywords: *Intrauterine, Intrabdominal, Macerated, Pregnancy and Laparotomy.***Corresponding author:****Dr. Asma Ashiq,**

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INTRODUCTION:

The occurrence of intrauterine with the extrauterine pregnancy is known as heterotopic pregnancy. The occurrence of ectopic pregnancy has direct association with the occurrence of both intrauterine and intrabdominal pregnancy. In different areas, there exist variations in the occurrence of ectopic pregnancy. All around the world, fewer cases have been presented regarding heterotopic pregnancy [1]. Abdominal pregnancy is very hard to identify. This difficulty persists even by high-resolution ultrasound. The occurrence of abdominal pregnancy is reported between the range of (50 – 90) percent [4]. Death rate can be decreased by in time identification and suitable treatment. In the treatment of placenta, there exists a difficulty. If the placenta is not taken off, then the risk of morbidity and death increases. If it is taken off, then bleeding can start that could lead to death.

CASE REPORT:

This female case was about thirty years of age. She was in a third pregnancy. Her previous vaginal deliveries were normal. After checking by Dai, she was presented to the emergency of the hospital. During this pregnancy, ultrasound and antenatal examination were not done. She was found with a record of 8 months amenorrhea. Her last menstrual period was unknown. No uterine contractions were observed and the patient was afebrile. Blood pressure of patient was 110/70 mmHg and pulse were 88/min. Fetal heart sound (FHS) was 142 beats/min after assessment of the abdomen. Thirty-four weeks was the fundal height. During this assessment, a dear macerated male baby

was delivered by her. The weight of the baby was 1000 grams. After some time, placenta with membranes was taken off. Other congenital abnormalities were not observed. After delivery, the pelvis was examined. Cervix was found a multiparous and a small amount of bleeding was also observed. Abdominal examination was also carried out. FHS was 144 beats/min and fundal height was 30 weeks. No uterine contractions were observed. The blood group of patients was A -ve. By using ultrasound, the place of the fetus was examined. For the crossmatch of blood, the patient and normal indications were sent. Inside an intact amniotic sac within the abdominal cavity, the alive fetus was present on opening the abdomen. Pfisteria incision was used for opening the abdomen. A small segment of momentum was present stick to sac. This segment was attached, cut and tied. Hemoperitoneum was not found. A live female baby in normal condition was born after amniotomy. Apgar value of baby was 4/10 and 6/10 at 1 and 5 minutes. The weight of the baby was 1800 grams. It is surprising to note that because of pressure, no irregularity was observed in the baby. The uterus was present on the left side. Sixteen weeks was the size of the uterus. The attachment of ovary and right fallopian tube was observed to the intestine and found attached to the right side. Placenta and membranes attached on the outside of uterus were taken off. After removal, hysterectomy was carried out immediately due to massive haemorrhage. The baby was transferred to the neonatal unit. After the operation, no issues were found. After seven days, the mother and baby were allowed to go home.



DISCUSSION:

Naturally, there found fewer cases related to the presence of both intrauterine and extrauterine pregnancies. In the population, the occurrence of ectopic pregnancy is directly associated with the occurrence of both intrauterine and extrauterine pregnancy [1]. Because of enhanced use of assisted reproductive methods with embryo transfer, there observed an increase in a number of such cases [2]. The patients living in rural areas, in developing nations and with low socio-economic standard, are mostly observed with this issue. This is due to less use of medical care by pregnant females and unavailability of diagnostic services [3]. This case report is about a female who belonged to a rural setting. It is always been difficult to identify abdominal pregnancy. This difficulty persists even with the use of high-resolution ultrasonography and by applying the best conditions. In different series, there exists a difference in identification with the range of (50 – 90) percent [4]. Before the operation, abdominal pregnancy can be exactly identified by magnetic resonance imaging (MRI). For identification, MRI is taken as the best technique [5]. The abdomen and pelvis were also observed laterally through X-Ray. Fetal parts to lying over the maternal spine are viewed and these are

helpful in diagnosis [5]. The incidence of abdominal pregnancy increases with increased maternal strain alpha-fetoprotein [6]. As the case reported, the cases of surviving ectopic tubal pregnancy are infrequent. On the other hand, abdominal and ectopic pregnancies are also discussed in history [7]. In history, the number of heterotrophic pregnancies found is only three. Two cases were from Tanzania and one from Kitui District Hospital [5, 8, 9]. Similar to our case report, Ramachandran reported the worst haemorrhage which was fatal [10]. In this case, six units of haemocoel and four pints of blood were lost. It is not taken off, then the risk of morbidity and death increases. Other complexities such as sepsis, serious abdominal discomfort, haemorrhage, intestinal obstruction, ileus and abscess formation are also associated with placenta if not removed [11]. According to the results of our study, oesophagal varices, peptic ulcer disorder, reflux esophagitis and NSAIDS induced gastric erosions were the common reasons for bleeding. These results are similar to other studies organized in our country [8 – 13]. The elevated rate of chronic infection with hepatitis C and hepatitis B causing end-stage liver disorder is responsible for the high prevalence of oesophagal varices. As compare to duodenal ulcers, the gastric ulcers were more frequent. The results of

Western studies are also similar to the outcomes of our research [6, 7]. Whereas, different results are shown by local case studies [9]. A common use of acid-suppressing drugs can be responsible for less prevalence of peptic ulcer associated with bleeding. In this population, alcohol intake is also associated more or less with UGI bleeding. Similar to local studies the incidence of tumours Upper GI tract is less [9]. In patients of UGI bleeding, the incidence of normal endoscopy was 18% in our research and between 9% to 21% in different studies [10].

CONCLUSION:

The results concluded that for the identification of exact causes of upper GI problems, the only suitable technique is UGI endoscopy. The patients are presented to the endoscopic unit mainly due to UGI bleeding and oesophageal varices. These illustrated a high incidence of chronic liver disorder and are common results of endoscopy.

REFERENCES:

1. Madhany, N.H.L (combined intra and extrauterine pregnancy in two patients. East Afr. Med. 1977; 54:505 -506.
2. Tango, F.U. A survey of 43 twin deliveries at Baga Moyo District Hospital, Tanzania. East Afr. Med. J 1983; 60:622-625.
3. Ramachandran K, Kirk P: Massive haemorrhage in a previously undiagnosed abdominal pregnancy presenting for elective cesarean delivery. Can J Anaesth, 2004;51:57-61.
4. Crabtree KE, Collet B, Kilpatrick SJ: Puerperal presentation of a living abdominal pregnancy. Obstet Gynecol, 1994;84:646-648.
5. M. Ludwig, M. Kaisi, O. Bauer and K. Diedrich. The forgotten child - A case of Heterotopic, Intraabdominal and Intrauterine pregnancy carried to term. Case report. Human Reproduction. May 1999; Vol. 14, No.5:1372-1374.
6. El-Karch A, Bedloe AM, Brown BL: Advanced abdominal pregnancy complicated by bilateral ureteral obstruction. A case report, J Reprod Med 1993;38(11):900-2.
7. Kranzfelder, D, Beier, H. J and Albert, P non-ruptured tubal pregnancy with the survival of mother and child. Geburt. Frauenheilk, 1988;48:369- 371.
9. D.K James, P.J. Steer, C.D. Weiner, B. Sonil, Second Edition. ELSEVIER: 1999; 55:983-997
10. D. Keith; Edmonds:6th edition. 1999; 7:61-73.
11. Sh. Motazedian: Term Asymptomatic abdominal pregnancy with good maternal and perinatal

outcome: A case report I'm J Med Sci 2000;25(1 & 2):76-80.

12. Nasira Tasnim and Ghazala Mahmood: Advanced abdominal pregnancy: A diagnostic and management dilemma. JCPSP 2005, Vol. 15(18):493-495.