

PERITONEAL EXTRA UTERINE PREGNANCY ABOUT A RARE CASE AND REVIEW OF THE LITERATURE

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ABSTRACT

Among all the factors that make abdominal pregnancy frequent in our context of developing countries: the frequency of genital infections high and the absence of pregnancy follow-up. In our case, the extra uterine pregnancy is peritoneally located and does not seem to respond to a specific risk factor. It is therefore considered primitive. The diagnosis is evoked by the presence of abdominal pain, often in a context of late menstruation. Gynecological examination found an enlarged uterus but not proportional to the presumed age of pregnancy, this was confirmed by ultrasound and determination of the Bhcg level. Depending on the acute nature of symptoms, surgical intervention is often essential. The latter is performed by general or local anesthesia depending on the urgency. A few cases of abdominal ectopic pregnancy carried to term or near term have been described in the literature, in these cases fetal fragility, polymalformation and anesthetic depression often contribute to the failure of resuscitation of the newborn.

KEYWORDS: Ectopic Pregnancy; Treatment; Prognosis.

INTRODUCTION

Abdominal pregnancy is defined as the implantation and development of the fertilized egg in part or in whole in the abdominal cavity in a primary or most often secondary manner.^{[1],[2]} This is a rare possibility in the course of a pregnancy, since it represents only 1% of ectopic ovular implantations according to Halaff.^[2] Although it is uncommon in developed countries, abdominal pregnancy has increased in countries with low medical density.^[3]

The progressive forms are exceptional with high perinatal mortality and occlusive, infectious and especially haemorrhagic maternal complications that can be very serious.^{[2],[4]} We report here in our article a new case of abdominal pregnancy stopped in the first trimester.

OBSERVATION

Mrs A.Z., 27 years old, has been married for 3 years. It is 2nd gesture and nulliparous with two spontaneous abortions at 2 months of amenorrhea, the last of which dates back to 6 months. Treated for pulmonary tuberculosis at age 18 with recovery; she had no other medical history and was not using contraception. His last period was December 01, 2020. She consulted on

February 8, 2021 (10 weeks of amenorrhea) for exacerbated abdominal pain in the right iliac fossa, associated with incoercible vomiting, but without metrorrhagia. The clinical examination showed a patient in good general condition, afebrile and her conjunctiva were normally colored. A sensitive defenseless abdomen with negative burney MC sign with to vaginal touch a normal uterus size clean vulva and closed cervix. The rest of the somatic examination was without abnormality. The abdominal-pelvic ultrasound examination, performed by 3.5 and 7.5 MHz probes, had shown an appendicular plastron appearance yet a latero uterine mass cannot be eliminated (figure 1); The uterus was slightly enlarged in size with an empty, fine and medial cavity line and a peritoneal effusion of great abundance (figure 2). A biological check-up objectified a level of BHCG 2052 Mui/ml and GB at the blood count 11,130 /mm³. A pelvic abdominal CT was requested objectivating at the level of the right iliac fossa an aspect of the ile al handles agglutinated extended at the pelvic level. (figure 3).

Before this clinical and paraclinical picture a surgical intervention was indicated whose exploration found a slightly increased uterus of size with agglutinated aspect of the intestinal handles around the trophoblast and a hematic effusion of great abundance for which they

proceeded to a release of the adhesions around the hematoma.

Haemostasis and peritoneal lavage were performed. Blood spoliation was compensated intraoperatively by transfusion of two red blood cells. The after-effects of the operation were simple.

Anatomopathological result: it is a hematic material containing trophoblastic and epiplonic tissue.



Figure 1: Appendicular plastron appearance or lateral uterine mass.



Figure 2: empty uterus with abundant effusion.

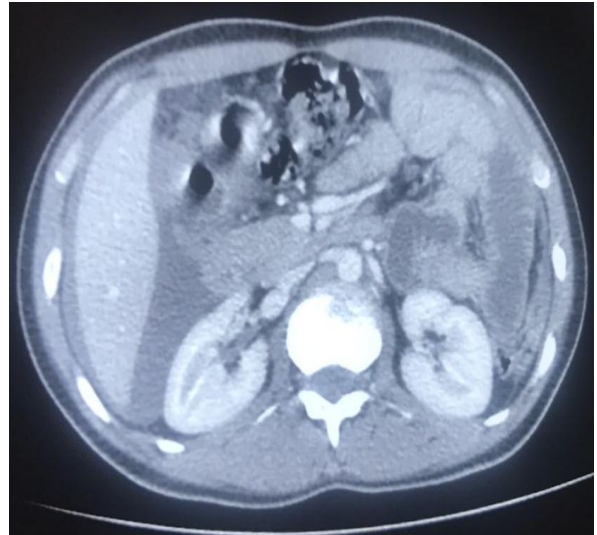


Figure 3: Agglutination of the ileal handles in the right iliac fossa.



Figure 4: Appearance of The Handles Agglutinated Around The Trophoblastic Tissue.

DISCUSSION

It seems that ABULCASIS is the first to describe a case of abdominal pregnancy (AP) in the tenth century.^[1]

➤ Epidemiology

AP is a rare localization of ectopic pregnancy.^[2] Its frequency varies according to the author. The great variability in the incidence of the disease depends essentially on the socio-economic level of the country and the quality of pregnancy and childbirth monitoring.^{[7],[8],[9]} but also on the high prevalence of sexually transmitted diseases, which cause tubal lesions and are frequently observed in Africa.^[6]

Racial predominance is reported in some publications, placing the incidence in the black race up to 10 to 25 times that of the white race.^{[10],[11],[12]}

Predisposing factors for AP are those of extrauterine pregnancy: genital malformations, specific or non-specific inflammatory sequelae, sequelae of tubal surgery and low socioeconomic background.^{[7],[10],[13],[14]} Some observations of AP on medically assisted procreation have been described.^{[15],[16]}

In the literature, AP is reported mainly in women over the age of 30 with few deliveries.^[17]

➤ Pathogenesis

Several AP classifications have been proposed. The oldest separates the primitive AP from the secondary AP.^[18] In the primitive form, the less frequent^[3], the egg can remain in free peritoneum until the 6th day after ovulation, by delayed oocyte capture, and can be fertilized and nestled on any structure of the cavity.^[5] To be confirmed, this form, the authenticity of which remains debated, must meet Studdiford's four conditions.^{[2],[18]}

- Both tubes and ovaries must be free of any lesion;
- Absence of uteroperitoneal fistula ;
- The reports of the ovular sac exclusively concern the peritoneal surface;
- The pregnancy must be young enough.

The secondary form is the most frequent; it can come from a ruptured tubal pregnancy or a tubo-abdominal abortion. It can be the consequence of an intrauterine pregnancy secondarily abdominal at the time of a rupture of scar of hysterotomy, a breach of uterine perforation or a rupture of a rudimentary horn.^{[2],[3],[5]}

This classification remains rather theoretical given the difficulty of specifying the integrity of the fallopian tube or uterus intraoperatively, especially if the pregnancy has progressed to near the term.^[2] It has little clinical and therapeutic impact.^[18] Some Anglo-Saxon authors have proposed a new classification based on gestational age or location of implantation.^[19] It distinguishes early AI whose gestational age is less than 20 A.S. with trophoblastic implantation primarily on the uterus, broad ligament, parietal peritoneum and Douglas cul-de-sac, from late abdominal pregnancy after 20 A.S.^[18]

CONCLUSION

Abdominal pregnancy, is a rare disease, and today is the prerogative of low level socioeconomic communities. The association of several signs makes it possible to suspect it, but diagnostic confirmation is given by ultrasound and by assaying Bhcg levels.

The presence of an ectopic pregnancy of location other than salpingic should always be of concern to the practitioner. Table and misleading and may mimic that of other pathology including appendicitis.

Before a peritoneal extrauterine pregnancy diagnosed even asymptomatic, the logic is to perform emergency surgery for maternal rescue.

Cases of term extraction of newborns resulting from an ectopic pregnancy are reported by the literature are very rare and are not the rule.

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