Peripartum Management of an Advanced Viable Extrauterine Pregnancy

Abstract Type: Case Report/Case Series
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Introduction: Abdominal pregnancy is rare, especially with continuation into the third trimester. The condition has serious implications for the survival of both mother and baby. Most cases require termination of the pregnancy and few successfully deliver a live infant.

Case: We present the case of a 38 year-old primigravida with an abdominal pregnancy who successfully delivered a live infant at 30 wks gestation.

Abdominal pain was an early feature of the pregnancy, and the diagnosis was made after three emergency room attendances between 17 and 19 weeks. An MRI scan demonstrated a live extra-uterine fetus with placenta implanted in the right abdominal wall extending into the pelvis, with possible colonic involvement. Although the risks were fully discussed, the patient elected to continue the pregnancy. She was transferred to our institution at 27 weeks gestation for multidisciplinary care with input from obstetrics, anesthesiology, neonatology, radiology, hematology, and both general and vascular surgery. Abdominal pain recurred throughout the pregnancy, intermittently requiring opioid analgesia.

Elective preterm delivery was carried out at 30 weeks gestation due to worsening pain. Dexamethasone was used to improve fetal pulmonary maturation pre-operatively. A combination of regional and general anesthesia was planned, and large bore peripheral cannulae and internal jugular lines were inserted prior to anesthesia. A thoracic epidural (T7/8) was first sited for post-operative analgesia, then intravascular occlusion balloon catheters were inserted under spinal anesthesia (1.75mls 0.5% heavy bupivacaine). The parturient was then positioned supine with left lateral tilt and general anesthesia induced using a rapid sequence technique (thiopentone 500mg, suxamethonium 150 mg). Anesthesia was maintained with isoflurane, oxygen and nitrous oxide, in addition to fentanyl and atracurium. A 1390g female infant was delivered through a midline laparotomy. Despite the intention to leave the placenta in-situ, it spontaneously partially separated, bleeding profusely. Hemorrhage was managed initially by clamping, and later embolisation, of the supplying vessels. Estimated blood loss was 4.9l; crystalloid/colloid solutions and blood products (red cells, fresh frozen plasma, cryoprecipitate and platelets) were required. After 8 hours in surgery, the patient was admitted to ICU for 24 hours.

She was discharged from our institution after one week, while her baby spent 9 weeks in hospital.

Discussion: This high-risk case highlights the importance of multidisciplinary care throughout pregnancy and delivery in order to achieve a successful outcome. Preparation for potential massive and rapid blood loss in the event of partial placental separation is paramount, as uterotonics will not be useful in terminating the hemorrhage.

Reference: 1. IJOA 2001;10:321-4