



## Case Report

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# Abdominal twin pregnancy a description of one case managed in N'Djamena Mother and Child Hospital (Chad)

Saleh A<sup>1</sup>, Gabkika BM<sup>1\*</sup>, Foumsou L<sup>1</sup>, Diarra D<sup>1</sup>

<sup>1</sup> Department of gynecology and Obstetrics, N'djamena Mother and Child Hospital

## Abstract

**Introduction:** Abdominal twin pregnancy is a rare condition characterized by the implantation and the development of two eggs in the abdominal cavity. We report a case of secondary abdominal twin pregnancy with fetal death. **Case presentation:** Patient of 22 years, 2 pregnancies, a living child, with a history of salpingitis, was referred from surroundings hospital to N'Djamena Mother and Child Hospital for suspicion of uterine rupture in a the context of fetus death in utero. Clinical examination allowed us to retain the diagnosis of abdominal twin pregnancy. We performed an emergency laparotomy. Per operative discoveries were: an average hemoperitoneum, a uterus with a size of grapefruit carrying a breach of old appearance at the right corneal level clogged by the epiploon, 2 intra-abdominal amniotic sacs in which extracted the first fetus dead macerated weighing 2800 g and second fetus died recently weighing 2250 g. The placenta was partially detached and located on the posterior wall of the abdomen. We removed the placenta without incident. The operative courses were simple. **Conclusion:** Management of abdominal twin pregnancies is similar to the single abdominal pregnancy.

**Keywords:** Abdominal twin pregnancy, Management, N'Djamena Mother.

## INTRODUCTION

Abdominal pregnancy is defined as primary or secondary implantation and development of the fetus, in the abdominal cavity [1, 2]. Early abdominal pregnancy is distinguished from advanced abdominal pregnancy that is diagnosed after the 20<sup>th</sup> gestational weeks [3]. The evolved forms beyond five months are exceptional in developed countries, but remains the commonest phenomenon in developing countries, where medicalization is still insufficient [4]. This is why Correa [5] has defined it as one of the reflections of underdevelopment. Available literatures data had treated this subject in the form of a single pregnancy. Cases of abdominal twin pregnancies are extremely rare. We report a case of abdominal twin pregnancy with died fetuses diagnosed in N'Djamena mother and child hospital.

## CASE REPORT

Mrs. F. A. 22 years old, second gesture, one living child, with an antecedant of salpingitis, was amitted in N'Djamena Mother and Child hospital for suspicion of uterine rupture in a the context of death in utero. The patient hadn't attended prenatal consultation, and had visited firstly a surrrounding hospital for abdominal pain, bleeding. The initial examination concluded that there was in utero death with fetus at term. Cervical maturation using the misoprostol was started. This treatment has exacerbated the abdominal pain, which had motivated the reference to N'Djamena Mother and Child Hospital for a better care. General examination at admission revealed: a patient with pale mucosa, the blood pressure was 90/60 mm Hg and the pulses were 95 / min. The abdomen was very sensitive to palpation. The uterus wasn't appreciable because of the pain, however the fetal poles were perceptible. Vagina examination revealed a posterior and closed cervix.

Obstetrical ultrasound showed an empty uterus with increased size (Figure 1), two fetuses out of the uterine cavity whose biometries had corresponded to 37 gestational weeks. No activity was observed. A liquid was noted in the Douglas and the Morrison space. The placenta was inserted on the posterior wall of the abdomen (Figure 1). The hemogram had showed normochromic normochromic anemia with a hemoglobin level of 6.5 g / dl. An emergency laparotomy was performed. Per operatoire findings were: an haemoperitoneum of 1 L that was aspirated, an enlarged uterus bearing an old breccia at the right cornual that was surround by the epiploon and the presence of 2 amniotic sacs (Figure 2) whose opening of

\*Corresponding author:

Gabkika BM

Department of gynecology and  
Obstetrics, N'djamena Mother  
and Child Hospital

Email: kickbray[at]yahoo.fr

the first was followed by extraction by podalic pole of a macerated fetus, female sex weighing 2800 g. Then the opening of the 2nd amniotic sac, allowed the extraction of a recent dead fetus weighing 2250 g (Figure 3). The placenta was only partially detached and localized on the posterior wall of the abdomen. We proceeded to the removal of the placenta without any incident (Figure 4). The remaining of the surgical procedure was normally performed. Two blood unit group O and positive rhesus were transfused in per operative time. The follow-up was simple and the patient was discharged on the 5th day, a contraceptive device using progesterone was instituted. The screening of beta HCG level was done and the level stay normal more than a year later.

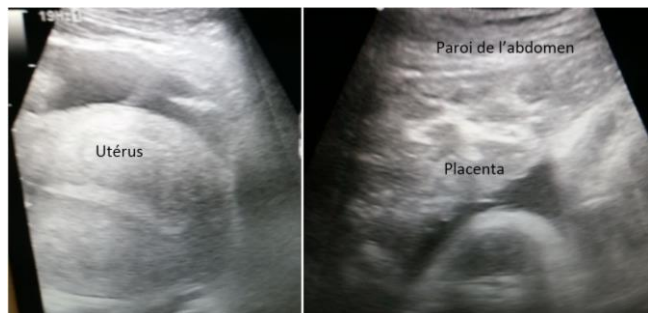
## DISCUSSION

The incidence of abdominal pregnancy varies from one country to another. Two factors depending on the socio-economic level of the country seem deeply to influence it: the incidence of the genital infection and the insufficiency of prenatal surveillance [3]. Abdominal pregnancy is exceptional in rich countries and it represents 1 / 7,000 to 1 / 15,000 deliveries [6, 7]. However, it is common in developing countries and reached the incidence of 1 case for 1134 deliveries to 1 case for 2583 deliveries [3, 7, 8]. In Chad, there was not an exhaustive study that had estimated the incidence. However Gabkika [9] and Djongali [10] had reported each one a case of abdominal pregnancy in the recent past.

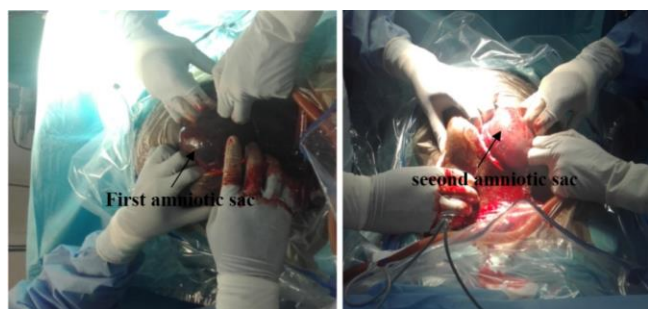
According to the pathophysiology of abdominal pregnancy, two different entities are identified: the primary and the secondary abdominal pregnancy. The primary abdominal pregnancies are due to the implantation of the gestational sac in the peritoneal cavity linked to the delay or the failure of ovula capture. The secondary abdominal pregnancies, which are the most frequent, resulting either from a tubal or abdominal abortion, from a tubal pregnancy rupture or from the migration of an intrauterine pregnancy through an uterine breach [1, 2, 3]. With regard to our intraoperative findings, we classify our case in the latter group. The presence of a uterine old breccia colmated by the epiploon evokes a tubal rupture

The clinical diagnosis is often difficult but a group of signs can orient the diagnosis. These signs are: a frequent episode of abdominal-pelvic pain, a persistent nausea and vomiting, metrorrhagia, and anemia [3, 11]. In this case, the absence of prenatal surveillance can explain the delay of the diagnosis. The ultrasound remains the main exam with can help to make the diagnosis of abdominal pregnancy [12]. This confirms the ultrasound findings in N'Djamena Mother and Child Hospital that had shown an empty uterus and the presence of 2 fetuses outside the uterus and specially placental insertion in the posterior wall of the abdomen. Surgery remains the only therapeutic procedure used to treat an abdominal pregnancy [3, 13, 14]. This surgical management is nuanced according to fetal viability and maternal hemodynamic status [3]. When the fetus is died in utero, so as not to expose the mother to infectious risks and bleeding disorders, a regulated intervention is indicated. But some authors like Kangulu [11], Alpana [13] and, Ke H [14] propose to wait a few weeks before intervening because the placental involution can reduce the intraoperative hemorrhage risk. In this case, although the fetuses were died, we had performed an emergency laparotomy which aimed to save the mother that was in instable hemodynamic state.

The particularity of laparotomy for abdominal pregnancy is linked with the placental location and insertion. Because of the risk of uncontrollable haemorrhage, attempts to remove the placenta are strictly prohibited if the insertion touch an abdominal organ [3, 6, 8, 11, 12, 13]. The spontaneous resorption of this placenta in situ is to be controlled by ultrasound and the determination of placental hormones [15]. This monitoring is unfortunately difficult to achieve in the poor medical conditions [13, 15]. In our case, localization of the placenta on the posterieur wall of the abdomen made the placenta removal without any complication. The partial placenta removal that was observed intraoperatively would probably due to undisclosed trauma or superficial insertion of the placenta. The placenta abruptio is cited among the etiologies of in utero death. Several series [16, 17, 18] had reported a few cases of utero death. In addition to this finding, the current literature reports that the fetal prognosis is worst in case of abdominal pregnancy with a fetal lethality varying from 75% to 95% [1, 3, 19] due to the defective vascularization of the placenta, the fetal hypotrophy and fetal malformations. Moreover, the weight difference between the two fetuses allows one to say that weightier fœtus was receiving the blood from the weaker. According to the literature, this



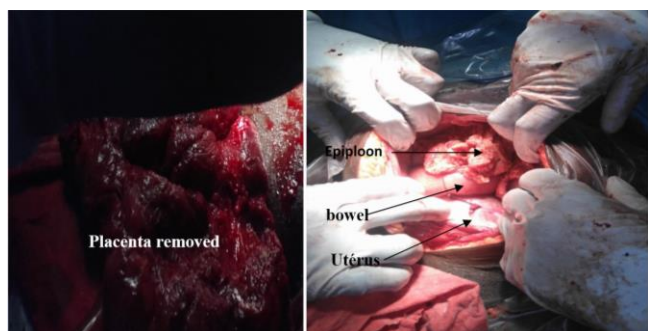
**Figure 1:** Ultrasound showing on the left side: an empty uterus and on the right side a placenta inserted in the posterior wall of the abdomen



**Figure 2:** per operative view showing on the left side the first amniotic sac and on the right side, the second amniotic sac



**Figure 3:** post operative view showing dead fetuses



**Figure 4:** Per operative view showing on the left side the placenta removed and the uterus, the epiploon and the bowel on the right side

syndrome is often met in cases of bi-amniotic mono chorionic pregnancies [20].

The maternal prognosis depend on the delay to diagnose abdominal pregnancy and the attitude towards the placenta. In our case, the maternal prognosis was good and the patient was discharged on the 5th postoperative day. No maternal complications were noted in the long term (beyond 8 months).

## CONCLUSION

The management of twin abdominal pregnancies is similar to that of single abdominal pregnancy. Placenta removal is possible when it is inserted in a less vascularized area and therefore less dangerous. Maternal and fetal prognosis are like those of a single abdominal pregnancy.

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