

CASE REPORT

Cesarean-section Delivery of Full-term Ectopic Pregnancy in Broad Ligament

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ABSTRACT

Broad ligament pregnancy is a rare form of ectopic pregnancy. Such pregnancy reaching term with favorable fetal outcome is even rarer. We describe a case of secondary extraperitoneal ectopic pregnancy diagnosed on laparotomy with favorable fetomaternal outcome.

Keywords: Broad ligament, Cesarean section, Ectopic pregnancy.

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INTRODUCTION

Abdominal pregnancy accounts for approximately 0.01% out of 1 to 2% of all ectopic pregnancies. Broad ligament pregnancy reaching full-term gestation and delivering a viable healthy baby is an extremely rare phenomenon.¹ Broad ligament or interligamentous pregnancy is a type of abdominal extraperitoneal ectopic pregnancy. A broad ligament pregnancy usually results from trophoblastic penetration of tubal pregnancy through the tubal serosa and into the mesosalpinx, with secondary implantation between the leaves of broad ligament.² Here, we describe a case of secondary extraperitoneal ectopic pregnancy diagnosed on laparotomy.

CASE REPORT

An unbooked 21-year-old patient G2P1L0 presented to our emergency room with history of 40+2 weeks

amenorrhea and pain in abdomen for the past 2 to 3 days. Past history revealed that the patient had a lower segment cesarean section (LSCS) of a stillborn child 15 months earlier. She was not on any medication and family history was insignificant. Her vital parameters were found within normal limits. General physical examination and systemic examination were within normal limits. On abdominal examination, uterus was of 36 weeks size, soft, nontender, and clinically liquor was found to be normal. Fetal heart sound was present. Per vaginal examination was not done. Ultrasonography showed single live fetus in oblique lie with low-lying placenta totally covering the internal os. She was thus taken for an elective LSCS for placenta previa under spinal anesthesia. On opening the abdomen, only the placenta was visible. On further exploration, baby was found in the sac in the left side of the abdomen. Anterior wall of the sac was cut open. Placenta was found on the right lateral aspect of the sac lying in the broad ligament (Fig. 1), and it could be removed without causing undue hemorrhage. Placenta was adhered to the right fallopian tube and ovary, so salpingectomy was performed on right side and adhesions were removed and right side ovary was saved. A viable female fetus of 3 kg was delivered. Omental adhesions were encountered, which were separated by sharp and blunt dissection. A diagnosis of right broad ligament pregnancy was made. Both the tube and ovary on the left side were found to be normal. Uterus was 12 to 14 weeks in size,



Fig. 1: Uterus (U) just after extraction of baby along with attached fallopian tube (T) and placenta (P) inside broad ligament

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normal, firm, and deviated toward left side. No adhesions were found on the left side. Stitches were removed on the 7th postoperative day. Histopathological examination revealed unremarkable placenta and membranes. The umbilical cord revealed the presence of three vessels. The patient recovered well without any untoward occurrence. Baby was doing well.

DISCUSSION

Advanced abdominal pregnancy (AAP) can be classified as being primary or secondary.² Primary AAP occurs when the fertilized ovum implants directly into the peritoneal cavity; primary AAP is the less common type. Secondary AAP occurs when the fertilized ovum first implants in the fallopian tube or uterus, and then due to fimbrial abortion or rupture of the fallopian tube or uterus, the fetus comes to live and develop in the mother's abdominal cavity.³ The rate of maternal mortality has been reported to be as high as 20%, and the perinatal mortality rate ranges between 40 and 95%.⁴ This is mostly because of the fact that most cases of AAP are missed and are only diagnosed during surgery.⁵ In our case, the patient survived and did well postoperatively. Most cases of AAP have an abnormal lie.⁵ Our case had an oblique lie. Once diagnosed, the definitive management of such cases of AAP is emergency laparotomy

and termination of pregnancy,¹ as was done in our case. In the literature reviewed, we found that in most of the cases, the diagnosis was missed preoperatively and our case was no exception, but unlike other cases the maternal outcome was favorable in spite of it being a term pregnancy. This case tells us to have a high index of suspicion on radiology for cases of AAP so that proper management can be instituted and a favorable outcome obtained. Moreover, patient should be advised to report early for an antenatal checkup.

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