

Abdominal Pregnancy with Hemorrhagic Placenta: About a Case at the Mother and Child Health Center of Zinder

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How to cite this paper: Garba, S.O., Oumara, M., Lankoande, Z.S., Amadou, I.A., Laoul, H., Ibrahim, N., Adamou, H. and Nayama, M. (2023) Abdominal Pregnancy with Hemorrhagic Placenta: About a Case at the Mother and Child Health Center of Zinder. *Surgical Science*, 14, 84-89.
<https://doi.org/10.4236/ss.2023.142011>

Received: January 10, 2023

Accepted: February 10, 2023

Published: February 13, 2023

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Abstract

Background: In developing countries maternal mortality and morbidity are most often due to the late to consult, poverty and ignorance. Added to this is, the under-medicalization of the health system. The objective of study is to report a case of late consultation and its consequences and make recommendations to improve: case of abdominal pregnancy with hemorrhagic placenta at the Health and Mother Center (CSME) in Zinder/Niger. **Clinical Observation:** We describe a case of abdominal pregnancy with hemorrhagic placenta in a 24-year-old woman, without profession, resident in the city of Zinder with a low economic level, consulted for abdomino-pelvic pain. She had a notion of amenorrhea for 5 months without any consultation made. She was pale, feverish and had abdominal pain. Ultrasound revealed a 23-week-old fetus and an empty uterus. The diagnosis was abdominal pregnancy. A laparotomy was performed and a The morbidity was hysterectomy and anemia. The postoperative period course was complicated with anemia. The patient was cured on the 9th day with a good vital prognosis. **Conclusion:** Abdominal pregnancy occurred in a patient who presented a risk factor. Ultrasound was the key diagnostic test. Surgery was the treatment of choice and the prognosis depends on the earliness of the consultation. Community awareness and early consultation with health services can improve the prognosis of abdominal pregnancy.

Keywords

Abdominal Pregnancy, Hemorrhagic Placenta, CSME, Zinder

1. Introduction

Abdominal pregnancy (AG) is an exceptional localization of ectopic pregnancy, where implantation and development of the fertilized egg takes place in the abdominal cavity, it complicates 1% to 4% of pregnancy [1]. The diagnosis of abdominal pregnancy is still difficult because of the delay in prenatal consultations and the use of care, so the diagnosis is often made after a complication [1] [2] [3]. Ultrasound plays a key role in the diagnosis of AG. The treatment is always surgical. As for the maternal prognosis, it most often depends on the precocity of the intervention and the intervention itself [2]. We report a case of abdominal pregnancy with hemorrhagic placenta at the Mother and Child Health Center (CSME) of Zinder in Niger. The objective: To describe the diagnosis, management and prognosis of abdominal pregnancy at the health and mother center of Zinder.

2. Comments

We describe a case of abdominal pregnancy with hemorrhagic placental abruption in a 24-year-old woman, without profession, of Muslim faith, resident in the city of Zinder with a low economic level, consulted in the emergency room for abdomino-pelvic pain. She has a history of 5 pregnancies 3 live births and an operated GEU; she had a notion of amenorrhea for 5 months without any consultation. She felt dizziness and asthenia 48 hours before admission. The examination found a clear conscience an altered general state, T: 39°C, TA: 10/6 cmHg, Pulse: 108/minute FR: 26/minute.

The conjunctivae were discolored. She felt pain on palpation of the abdomen, more accentuated in the hypogastrium. The cervix was closed and the vaginal examination is clean. Palpation reveals a sensitive abdomen with mass perception in the right iliac fossa. The room ultrasound revealed a 23 week gestational age fetus and an empty uterus with effusion in the pouch of Douglas. The blood count showed normochromic normocytic anemia with a hemoglobin level of 5.3 g/dl. The indication for surgical treatment was the choice. A laparotomy passing through the old surgical scar under anesthesia was performed. At the opening the placenta was inserted on the uterus, partially detached and haemorrhagic. The aspiration of 520 ml of hemoperitoneum was done. The left fallopian tube was invaded by the insertion of the placenta, the residual stump of the right fallopian tube of approximately 3 cm was identified. A macerated dead female fetus weighing 530 g with a hematoma weighing 830 g had been extracted from the abdominal cavity by foot traction. A proximal umbilical cord ligation was performed and a haemostasis hysterectomy was performed. She received a blood transfusion of 900 ml of blood intraoperatively. The immediate postoperative course was marked by hemodynamic stability with monitoring of the hemoglobin level which was 6.3 g/dl on the 1st postoperative day. A resumption of transit was noted on the 2nd postoperative day. She had benefited from a transfusion of a third bag of 450 ml on the 3rd operative day. She had benefited from psycho-

therapy because of the induced morbidity: Ablation of the uterus. The evolution was favorable clinically and paraclinically, with a good prognosis, the patient was cured on the ninth postoperative day with early consultation interest counseling (Figures 1-5).



Figure 1. Placenta adheres fundus.



Figure 2. Fetus 23 weeks.

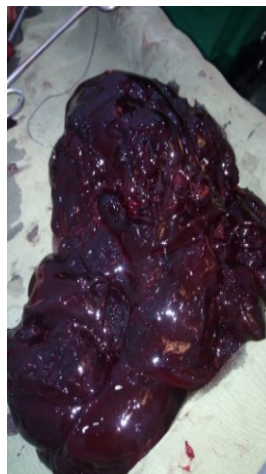


Figure 3. Hematoma weighing 870 g.



Figure 4. Site placenta insertion.



Figure 5. Hysterectomy specimen.

3. Discussion

AI is very common in developing countries and occurs at an advanced stage (1/2000 deliveries) [1]. While it is of low incidence in developed countries (1/10,000 - 15,000 deliveries) [2] [3] [4]. This difference is due to the proportions of risk factors for the occurrence of ectopic pregnancy, which depends above all on the socio-economic and health level of the country. For developed countries, medically assisted procreation and the use of intrauterine devices exposes to risk, on the other hand in developing countries several risk factors explain the high prevalence of AI; genital infections, history of pelvic surgery and septic abortions, and insufficient pregnancy follow-up [5] [6] [7] [8]. The profile of GA described by the authors is similar to our case which is that of a patient who had a low socio-economic level, a history of operated GEU, a pregnancy not followed up and who consults late. A group of signs can guide the diagnosis towards an abdominal pregnancy [9] [10] [11]—digestive disorders: nausea, vomiting, constipation, sub-occlusion,—abdominal-pelvic pain concomitant with fetal movements with or without metrorrhagia,—anemia with impaired general condition—a very superficial fetus often in an atypical, high transverse position. We can palpate a second pelvic mass corresponding to the enlarged but empty uterus—On vaginal examination, the cervix is often fixed under the pubic symphysis, it is hard and long—sometimes the picture is dominated by a progressive complication such as internal or external bleeding, anemia, jaundice, oliguria, toxi-infectious syndrome.

Most of these signs were present in our patient. Ultrasound is the key diagnostic examination, it holds an important place in the confirmation of the diagnosis by objectifying the fetus outside the uterus and it makes it possible to visualize the site of the aberrant insertion of the placenta [2] [4] [12].

When the extraction of the placenta leads to massive hemorrhages not controlled by conventional techniques to ensure haemostasis, it is recommended to use hemostatic: hemostatic matrices for surgical care which act on the coagulation disorder to ensure haemostasis [1]-[13]. But these hemostats are not always available in our working conditions. Thus, for other authors, it is more prudent to leave the placenta in situ after proximal ligation of the umbilical cord [1] [14] [15]. This is necessary especially if the placental insertion is done on vital organs or large vessels and is all the more advantageous due to the unavailability of blood products in our country. In our case, the placenta was inserted on the uterine and hemorrhagic fundus, which led to a hysterectomy for hemostasis. Clinically, anemia was monitored by monitoring hemoglobin. Maternal mortality is 7 times higher in cases of GA than in other ectopic pregnancies [12] [13] [14] [15] [16]. The evolution was favorable in our patient; maternal morbidity was dominated by anemia and hysterectomy.

4. Conclusion

Abdominal pregnancy was diagnosed late, it occurred in a woman who presented a risk factor for ectopic pregnancy (pelvic surgery for GEU). The diagnosis was guided by the clinic, then confirmed by ultrasound. Surgery was the treatment of choice. Morbidity was heavy and dominated by anemia and removal of the uterus. Community sensitization on sexual and reproductive health, availability, accessibility, and early consultation of health services, can decrease the incidence of ectopic pregnancy; improve the prognosis of abdominal pregnancy.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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