Primary Hepatic Pregnancy

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Ectopic Pregnancy is a potentially fatal condition if not diagnosed and treated on time. The incidence of Abdominal Pregnancy is 1.4% of all ectopic pregnancy, of which Primary Intrahepatic Pregnancy constitutes only 0.03 %.

Abstract
A case report of primary hepatic pregnancy in a peripheral hospital in Oman, Dr K.V.S.Prasad, Dr.Monisha Seth, Dr. Rupa Umesh, Dr. Farag al Farag, Dr.Shivakumar Department of Surgery and Obstetrics, Ministry of Health Hospital, P O.Box: 3, Postal Code: 418, Sinaw, Sultanate of Oman.

Introduction
Ectopic Pregnancy is a potentially fatal condition if not diagnosed and treated on time. The incidence of Abdominal Pregnancy is 1.4% of all ectopic pregnancy, of which Primary Intrahepatic Pregnancy constitutes only 0.03 %. Clinical suspicion is important in the early diagnosis of an Ectopic Pregnancy. Following a positive urine or serum B-HCG, a transvaginal ultrasonography should be performed early to rule out an ectopic gestation. IUCD use marginally increases the ectopic risk. Undetected Ectopic Pregnancy of 6 to 8 weeks gestational age may suddenly with acute abdominal pain, followed by a syncopal attack. This sequence usually heralds rupture of Ectopic Pregnancy and intraperitoneal hemorrhage, requiring aggressive management.

We attempt here to present a similar case of undiagnosed Primary hepatic Pregnancy presenting in a collapsed state at our peripheral hospital, on 5.2.2003.

Case Report
A 30Year old G4P2 L1A1 presented to the ER in a collapsed state on 05-02-03 with history of sudden onset of severe pain in the Right flank and lower abdomen.
Patients LMP was on 05-01-03(scanty flow lasting for 2days). Patient had visited a the previous day, urine pregnancy test was positive and a pelvic ultrasound showed evidence? Shadow of early intrauterine gestational sac with normal adnexa and was advised to follow-up in the hospital the next day.
History of IUCD usage present, removed one year back.
Obstetric history: A living male 5years old, history of IUD at eight months and history of evacuation and curettage for missed abortion.

Clinical findings:
Pallor present, Tachycardia, and BP: 90/70mmhg.
P/A: Severe tenderness present in the right flank and lower abdomen with guarding.
P/V: Os closed, Uterus normal size. Tenderness was present in the Right fornix with fullness in both fornices, cervical excitation test was positive. No evidence of any bleeding per vagina. Ultrasonography: showed evidence of free fluid in the pelvis, right paracolic gutter and sub hepatic space.

As the patient started deteriorating, patient was posted for laparotomy after initial resuscitation in view of hemoperitoneum with positive pregnancy test.

Operative findings:
Laparotomy was done by a midline incision.
About three liters of blood was found in the peritoneal cavity.
Uterus and both the adnexa were normal. No evidence of any bleeding/tubal abortion.
On exploration the source of bleeding was found to be from the inferior margin of right lobe of liver.
Fetus was seen floating in close proximity to the liver and profuse bleeding from the site of implantation in the liver.
The size of the fetus was corresponding to 6-8 weeks approximately. The vessels in the bed were ligated to attain hemostasis with suturing of the liver parenchyma. As the hemostasis was not satisfactory a decision to do perihepatic packing with insertion of a tube drain was taken in view of the hospital setup and the patient was transferred to a secondary care hospital. The patient was re-explored after 24 hours after the general condition of the patient stabilized and the packs were removed, on re-exploration the bleeding had totally arrested. The postoperative period was uneventful and the patient was discharged on the 6th postoperative day. The patient had received seven units of blood during the course of resuscitation and the procedure. The histopathology confirmed the presence of fetus with sac and placental tissue.

**Conclusion**
Immediate surgical management is required in the above-mentioned situation to save the life of the patient. The scanty flow that occurred one-month prior was not corresponding to the LMP as the size of the fetus was corresponding to 6-8 weeks of gestation. This suggests that history has to be supplemented with the other investigations at the earliest for early intervention.

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