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**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**<http://doi.org/10.5281/zenodo.1012326>Available online at: <http://www.iajps.com>**Review Article****ADVANCED ABDOMINAL PREGNANCY -A REVIEW**Fateme parooei ¹, Mahmood Anbari ², Morteza Salarzaei ^{1*}¹Medical Student, Student Research Committee, Zabol University of Medical Sciences,
Zabol, Iran² Zabol University of Medical Sciences, Zabol, Iran**Abstract:**

Introduction: The egg cell naturally implants inside the endometrial cavity. Blastocyst implantation everywhere else other than the endometrial cavity is considered as an ectopic pregnancy the prevalence of which is around 2 percent and accounts for 6 percent of pregnancy-related mortality cases in mothers.

Methods: In this review article, the databases Medline, Cochrane, Science Direct, and Google Scholar were thoroughly searched to identify the Advanced abdominal pregnancy. In this review, the papers published until early January 2017 that were conducted to study the Advanced abdominal pregnancy were selected.

Results: In recent years, the likelihood of ectopic pregnancy has increased. However, ectopic pregnancy hardly results in birth of a live infant. Some reasons for increased ectopic pregnancy include increased pelvic infection and tube damage cases as a result of assisted reproductive techniques and fallopian tube surgeries.

Discussion and Conclusion: Ectopic pregnancy may occur simultaneously with intrauterine pregnancy, and this is called heterotypic pregnancy. The diagnosis is very hard in these cases. The heterotypic pregnancies occur hardly with the incident rate of 1 for every 30000 intrauterine pregnancies.

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INTRODUCTION:

The egg cell naturally implants inside the endometrial cavity. Blastocyst implantation everywhere else other than the endometrial cavity is considered as an ectopic pregnancy the prevalence of which is around 2 percent and accounts for 6 percent of pregnancy-related mortality cases in mothers (1). Almost all abdominal pregnancy cases are owing to implantation in the peritoneal cavity that are created as a result of Tubal pregnancy abortion or early rupture of the tube and it is very unlikely that the placenta attaches to the uterus or adnexa in advanced abdominal pregnancy cases (2). The prevalence of abdominal pregnancy in high gestational age ranges from 1 in 25000 to 1 in 85000. The number of the reported cases of 26 weeks and higher is rare. The symptoms of advanced abdominal pregnancy are vague and nonspecific (3). The doctor needs to be highly doubtful about his diagnosis. However, most of the women are asymptomatic. Ultrasound findings do not provide definite diagnosis in most cases and whenever an abdominal pregnancy is diagnosed, MRI is conducted to obtain the maximum information (4). Abdominal pregnancy is a risky status. The main factor determining its clinical treatment is gestational age. Before the 24th week of pregnancy, a conservative treatment is hardly accepted. However, some recommend that of abdominal pregnancy is diagnose after 24 weeks, the patient should be monitored in hospitalization conditions until the fetus is capable of surviving (5). This treatment method is associated with the risk of sudden and risky hemorrhage.

METHODS:

In this review article, the databases Medline, Cochrane, Science Direct, and Google Scholar were thoroughly searched to identify the Advanced abdominal pregnancy. In this review, the papers published until early January 2017 that were conducted to study the Advanced abdominal pregnancy were selected.

FINDINGS:

In recent years, the likelihood of ectopic pregnancy has increased. However, ectopic pregnancy hardly results in birth of a live infant. Some reasons for increased ectopic pregnancy include increased pelvic infection and tube damage cases as a result of assisted reproductive techniques and fallopian tube surgeries (6). Abdominal pregnancy is very risky and its treatment depends on the gestational age. In most cases of abdominal pregnancy diagnosis, the pregnancy ends with indication. In abdominal pregnancy, the separation of placenta brings about severe bleeding that is resulted from the non-contraction of hypertrophic vessels (7). The full separation of placenta needs to be

conducted in cases other than those where the placenta is implanted on large vessels or vital organs. In most cases, leaving the placenta will reduce the likelihood of risky immediate bleeding. In such cases, the likelihood of abscess, adhesion, and intestinal obstruction will increase (8). However, if the placenta is left in its place, its regression should be monitored by B-HCG frequent control.

DISCUSSION AND CONCLUSION;

Blastocyst naturally implants in the endometrial coating of the uterine cavity and ectopic pregnancy occurs when the fertilized egg implants in a tissue other than endometrium. More than 90% of ectopic pregnancies occur in the fallopian tube (9). The risk of death in ectopic pregnancy is 10 times higher than intrauterine pregnancy and 50 times higher than abortion. The main causes of ectopic pregnancy include:

1. Mechanical factors such as Salpingitis, the adhesions around the tube, evolutionary abnormalities of the fallopian tube, the history of ectopic pregnancy, investigations on the tube.
2. Functional factors such as external immigration of the egg, return of menstrual blood, tube movement change, and taking pills containing only progesterone.
3. Applying different methods of fertility enhancement such as ovulation stimulation and the transfer of gamete in to the fallopian tube (10).

Ectopic pregnancy may occur simultaneously with intrauterine pregnancy, and this is called heterotypic pregnancy. The diagnosis is very hard in these cases. The heterotypic pregnancies occur hardly with the incident rate of 1 for every 30000 intrauterine pregnancies (11).

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