Placentation in Anterior Abdominal Wall – A Rare Phenomenon

Uma Singh, Priti *Kumar*
Department of Obstet and Gynecol, K.G.s Medical College, Lucknow.

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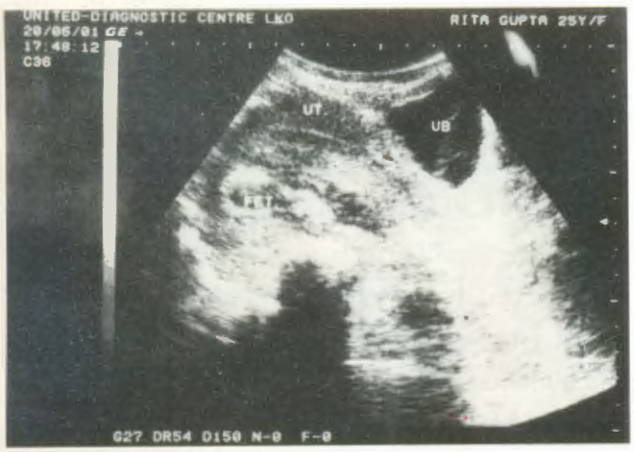
Mrs. 'R' aged 25 years P1 + 0, FTND 4 years back, alive and well, was admitted on 21.6.01 with complaints of three and half months of amenorrhoea with bleeding per vaginum for six days with severe pain in lower abdomen for one day. The pain was excruciating with localisation in the right iliac region not associated with fever or vomiting. She had voluntary termination of pregnancy one and a half months back at some private nursing home. A Clinical examination revealed the following – GC – satisfactory, anaemia +, Pulse – 120/ min, BP – 90 / 70mm Hg, pallor +, CVS and RS normal. An abdominal examination revealed vague illdefined lump in right iliac region, tenderness +, the bowel sounds were sluggish there was and no shifting dullness, guarding or rigidity. No reports of investigations were available. Hemoglobin was 8.0 gm%. The USG findings revealed a bulky uterus with good decidual reaction. Extrauterine gestational sac carrying a dead fetus with CRL of 12 weeks gestation was seen adjacent to the right side of the body of the uterus (Photograph 1). Placental position could not be clearly made out.



Photograph 1 : Placentation in anterior abdominal wall.

An emergency laparotomy was performed on the same day, as the patient was in agony and symptoms were not relieved by any medication. On opening the abdomen, the bowel and omentum were found adherent to parietal peritoneum anteriorly just above symphysis pubis and right iliac region. With careful separation of the bowel and omentum, a placenta like tissue was found embedded in the lower anterior abdominal wall. It was gradually removed and a few hemostatic sutures were taken at the placentation site. The fetus was lying in a well-formed sac, posterior to the uterine body on the right side. The left tube and the ovary formed a dense mass with the bowel and omentum, which could not be separated. The right tube and the ovary could not be clearly seen due to dense adhesions. They were not dissected further due to increased vascularity. Uterine body was normal and intact. The fetus was removed along with the placenta. The abdomen was closed in layers. The postoperative period was uneventful. A histopathological examination of the tissue revealed well-formed chorionic villi with haemorrhage.

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Correspondence :
Uma Singh
Department of Obstetrics and Gynecology,
K.G.s Medical College, Lucknow.

Discussion

This case is unique due to the occurrence of abdominal pregnancy and it's nidation in the anterior abdominal wall. An abdominal pregnancy follows early rupture or abortion of tubal pregnancy with a rare incidence of 1 in 3300 births[1]. Typically the growing placenta after penetrating the oviduct maintains the tubal attachment and also invades the surrounding viscera, and the fetus grows in the abdominal cavity. Rarely does the fertilized ovum get extruded and implanted on the visceral or the parietal peritoneum[2]. The incidence is high in tuberculosis and endometriosis[3]. The incidences of the malformed fetus and maternal mortality are high viz., six percent[4]. A typical presentation is acute pain in the abdomen followed by irregular vaginal bleeding. It is difficult to comment whether our case was that of a primary or secondary abdominal pregnancy.

References

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