

ADHERENCE BETWEEN PLACENTA AND OMPHALOCELE SAC

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The baby who had placental adherence between fetal site of placenta and omphalocele sac was presented. A 21 years old woman, gravida 2, parity 0, abortion 1 was admitted to the Selçuk University, Medical Faculty of Meram, Department of Obstetrics and Gynecologic, because of beginning the labor. Omphalocele was seen with ultrasonographie. Cesarean section was preferred according to desire of the family. A placental adherence between fetal site of placenta and omphalocele sac was detected during cesarean section. This adherence was divided and the baby was delivered. But baby died because of major cardiac anomalies. Anomalies such as omphalocel may be together with adherence between omphalocele sac and placenta or membranes.

Key words: Omphalocele, Placenta, Adherence

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INTRODUCTION

Omphalocele is an anterior abdominal wall defect characterized by herniation of the intraabdominal contents into the base of the umbilical cord, with a covering amnioperitoneal membrane. The most frequently herniated organs are the liver, bowel and stomach. Umbilical cord inserts into the sac. The incidence of omphalocele is 1 to 3 per 10000 live births. Most cases are sporadic but in some cases there may be a sex-linked or autosomal pattern of inheritance (1-2). In this report, a case which had placental adherence between fetal side of placenta and omphalocele sac was presented (Figure 1).

CASE

A 21 years old woman, gravida 2, parity 0, abortion 1, was admitted to the Selçuk University, Faculty of Meram Medicine, Department of Obstetrics and Gynecology because of beginning the labor. She did not know the certain date of her last menstrual period. There was no antenatal care and ultrasonographic examination. A year ago suction curettage was done to this patient because of hydatidiform mole. Her general physical examination was found to be normal. In her pelvic examination, cervical dilatation was 5 cm, the membranes were unruptured and the presentation of the fetus was breech.

In the ultrasonography, gestational age was 39th gestational week and omphalocele was seen. Other gross fetal abnormalities were not detected. Cesarean section was preferred according to the desire of the family. An interesting abnormality was seen on placenta during cesarean section. A placental adherence (approximately 40%) between fetal side of placenta and omphalocele sac was present. This adherence was separated and the baby who was 3000 gr and male infant was delivered with first minute Apgar score 3. There was a large omphalocele but only bowels were herniated.

Because of the respiratory insufficiency in spite of nasal and oral aspiration, application of airway and oxygen, the infant needed endotracheal intubation. Then the infant was resuscitated. Cardiac arrest occurred in spite of resuscitation. Despite the resuscitation and cardiac massage for 25 minutes, the baby died. Major cardiac anomaly and anus imperforatus were found after autopsy.

DISCUSSION

Embryologically, failure of fusion in the midline of gestation, results in an omphalocele. In omphalocele, the defect is located in the midline of anterior abdominal wall and herniated organs pass through the base of the umbilical cord, covered by a

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Figure 1. A placental adherence between fetal side of placenta and omphalocele sac.

membrane made up of two layers: internally, the peritoneum and externally, the amnion. The umbilical cord inserts into the sac. The ultrasonographic appearance varies depending on the size of the defect and herniated organ. The differential diagnosis of omphalocele should be done with gastroschisis, which is a full-thickness defect of the abdominal wall, usually to the right of the umbilicus (1-3). In this case, the baby had an omphalocele.

Omphalocele can be present as part of a syndrome (Pentalogy of Cantrell, Beckwith-Wiedemann Syndrome) or different anomalies. The incidence of anomalies with omphalocele is more than gastroschisis. The incidence of these anomalies including cardiac abnormalities (47%), genitourinary abnormalities (40%) and neural tube defects (39%) is very high (4-6). In this case, the baby had major cardiac anomalies and anus imperforatus. If omphalocele is diagnosed prenatally, to search carefully for other malformations and to perform fetal caryotyping is imperative. If the diagnosis could be established early parents could decide for termination of the pregnancy. But for our patient there was no prenatal care. Death is mainly due to cardiac abnormalities, chromosomal malformations, prematurity and respiratory insufficiency (5-6). In this

case, the baby died because of major cardiac anomalies. There is no consensus concerning the best method for delivery. The goal of management is the delivery of the fetus as close to term as possible. Delivery in a tertiary care center provides optimal care for the infant immediately at birth (7).

The pathologies such as adherence between fetal tissues or omphalocele sac and placenta or amniotic membrane are seen rarely. This pathology may be very hazardous for both fetus and mother. In this case, adherence between placenta and omphalocele sac was found coincidentally during the cesarean section. Anomalies such as omphalocele may be together with adherence between omphalocele sac and placenta or membranes. When omphalocele was detected, the probability of adherence between placenta and omphalocele sac should be kept in mind in order to prevent serious maternal and fetal complications.

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