



Rectus Abdominis Atrophy Identified at Cesarean Delivery

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Clinical Image

A 36-year-old gravida 6 para 1223 presented to Labor and Delivery at 29 weeks and 3 days gestation in preterm labor in the setting of two prior spontaneous preterm deliveries. Two days later the patient further progressed in labor and underwent a primary low transverse cesarean delivery for fetal malpresentation. Although initially not seemingly related, the patient had a history of a Wilm's tumor and leukemia at the age of 2 years old for which she underwent a laparotomy with left nephrectomy, chemotherapy, and radiation. Her abdominal examination was notable for a large, transverse subcostal incision that extended across the patient's abdomen.

During the cesarean delivery, no identifiable left rectus abdominis muscle was visualized. The right rectus abdominis muscle appeared normal with adipose-like tissue overlying the left abdominal peritoneum beginning at the midline. All other abdominal and pelvic anatomy appeared normal with the exception of dense intraabdominal adhesions and friable tissue. Upon subsequent



Figure 1: Abdominal scar ("Subcostal incision from prior laparotomy in 1986.").

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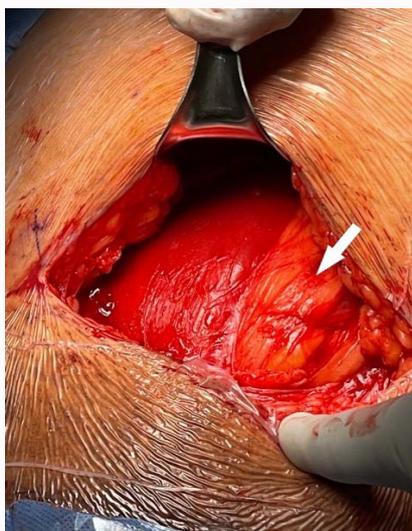


Figure 2: Atrophy of left rectus ("At the time of cesarean delivery, normal appearing right rectus abdominis muscle was found. No identifiable left rectus abdominis muscle with area instead covered in adipose-like tissue above peritoneum. Performed in 2020.").

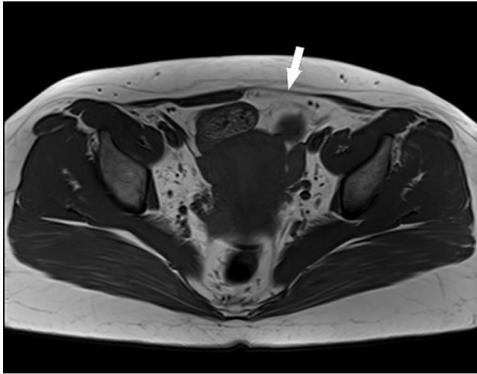


Figure 3: MRI ("Pelvic MRI from 2017 with no identifiable left rectus abdominis muscle.").



Figure 4: CT Abdomen/Pelvis ("CT abdomen/pelvis from 2014 with no identifiable left rectus abdominis muscle.").

chart review, the patient had completed a pelvic MRI three years prior and a CT abdomen/pelvis six years prior for pelvic pain. While not commented on in the report, no left rectus abdominis muscle was identified on imaging (Figures 1-4).

This case demonstrates likely left rectus abdominis muscle

atrophy secondary to iatrogenic ischemia from a prior abdominal procedure highlighting the importance of considering prior medical and surgical histories before routine, unrelated procedures as the expected anatomy and surgical landmarks may be subsequently significantly distorted or absent.