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RETAINED PLACENTA AFTER VAGINAL DELIVERY:A CASE REPORT

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ABSTRACT
A retained placenta is when the placenta is not delivered within 30 minutes of the baby's birth. It is a dangerous problem since it can lead to maternal morbidity and mortality.This case presents a 35 year old female, Primigravida 39.4 weeks in latent labour. Following normal vaginal delivery, there was retained placenta which did not separate after manual removal of placenta. Ultrasound and MRI pelvis findings were suggestive of adherent placenta at the fundus and extending upto serosal surface. This patient was managed medically and placenta expelled out spontaneously 10 days postpartum.

INTRODUCTION
Retained placenta being a common cause of obstetrical morbidity after vaginal delivery occurs in around 1–3% of deliveries. Retained placenta is defined when placenta fails to expulse spontaneously after vaginal delivery within a period of 18-60 minutes. Retained Placenta is failure of placenta to spontaneously separate after delivery of baby when there is massive hemorrhage in absence of placental separation and any remnants of placenta are there after spontaneous expulsion of placenta.[1-3] Placentas that fail to spontaneously separate can be a cause of significant surgical and hemorrhagic morbidity.[4,5] Untreated, retained placenta is considered the second leading cause of postpartum hemorrhage (PPH).[5,6]While Retained placenta is a complication in obstetrics being an infrequent complication during labour, it is important to recognize risk factors of patients and understanding management in reducing this morbidity.

KEYWORDS : *retained placenta, manual removal of placenta, post partum hemorrhage, maternal mortality*

CASE REPORT
A 35 year old female,primigravida presented at 39.4 weeks of gestation (dated by first trimester ultrasound) in labour. she had no history of leakage of amniotic fluid and vaginal bleeding. she had no any significant past medical history. The patient did not had any previous surgeries related to uterus. Patient had a good fetal movements, and the CST was reassuring.

COURSE OF LABOR
On admission cervix was 3 cm dilated and labour was augmented with 5U of oxytocin. Patient progressed well and after 5 hours of labour, there was a spontaneous normal vaginal

delivery. Cord was clamped and cord blood sample was taken, a gentle traction for 15 minutes was maintained to deliver placenta, however placenta didn't deliver.After delivery, (20U in 500ml RL) oxytocin drip IV was given in a continuous manner. In between bladder was emptied. After maintaining traction for further 15 minutes, still placenta didn't separate from the uterus. There was no active bleeding noted. After 30 minutes, tablet misoprostol 400 mcg was given sublingually and injection carboprost 250 mcg given after 1 hour. After explaining the risk of massive blood loss, proper consent of the patient was taken for manual removal of placenta in OT with a possibility of hysterectomy. Consent was taken regarding blood and blood products transfusion. After taking the consent for manual removal of placenta, the patient was urgently shifted to the operation theatre. After giving spinal anaesthesia,manual removal of placenta was attempted. Only 25% of the placental bits separated, rest 75% found to be morbidly adherent and sample was sent for histopathological examination which confirmed retained placenta.1 unit of packed cell volume was transfused intraop. Patient was shifted to ICU and ultrasound was performed which showed retained placenta and thinned out myometrium in the fundal region with internal vascularity. Procedure was abandoned as placenta was found to be morbidly adherent and patient was not having active bleeding.

POST OPERATIVE PERIOD

Patient was shifted in ICU with stable vitals and there was minimal per vaginal bleeding and patient was under close observation. Patient was started on injection piptaz 4.5gm IV TDS, injection metronidazole 100 cc IV TDS and injection amikacin 250mg IV BD for 7 days. Tablet misoprostol 200 mcg was kept per rectally every 4 hours. Total of 1800mcg tablet misoprostol was given. There was no active bleeding noted and uterus was tonically contracted. On day 2 CBC was done- Hb- 4.7gm/dl, TLC- 17,100/mcl, platelets- 1,93,000/mcl, LFT and RFT and other laboratory parameters were within normal limits. 3 units of packed cell volume and 4 units of fresh frozen plasma was transfused. On day 2 approximately 50 to 80grams blood clots were removed through vagina. Tablet 600mcg misoprostol per rectal was given. Approximately 200cc of blood clots expelled per vaginally after 14 hours on day 3.Then decision of exploration and examination under anaesthesia was taken on day 3. Blood clots were removed and placenta was still adherent to the fundal wall. 1 unit of packed cell volume was transfused intraop. Post exploration we performed ultrasound to rule out any rent in the uterine cavity and any intra abdominal hemorrhage and findings were suggestive of retained placenta in the fundus and multiple clots in the lower uterine body and cervix. Then tablet methergine 0.25mg thrice a day was started on day 4. One tablet mifepristone 200mcg stat was given. On day 4 Hb was 6.9gm/dl, TLC- 9,400/mcl, platelets- 1,62,000/mcl, beta hCG -650mIU/mL.1 unit of packed cell volume was transfused. Total of 7 units of packed cell volume and 4 units of fresh frozen plasma was transfused.On day 6 MRI abdomen and pelvis(figure 1) was performed which was suggestive of adherent placenta in the fundic region 68*51*54mm on and cervical canal is distended with blood clots. There is contiguous extension of this lesion through myometrium upto the serosal surface causing marked thinning of adjoining uterine wall in the fundic region on the left side.Hb- 8.9gm/dl, TLC- 15,800/mcl, platelets- 1,81,000/mcl. Tablet methergine 0.25mg

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thrice a day was continued and the decision to shift the patient to the ward was taken on day 8 as she was vitally stable. On day 9 she again passed blood clots. However, there was no active bleeding and patient was monitored for per vaginal bleeding. On day 10 placenta got expelled out spontaneously and completely(figure 2) and the specimen was sent for histopathological examination. Ultrasound was performed which revealed empty uterine cavity.(figure 2) There was no active bleeding. Histopathological examination confirmed maternal floor placental infarction with chorioamnionitis.

PATHOLOGY

Placenta was analysed,and the pathology report showed the specimen weighting 320gm. Grossly,placenta appears distorted. Section studied from the placenta shows chorionic villi showing extensive necrosis and calcifications with focal changes of infarction on the maternal surface. The membranes and the umbilical cord show acute inflammatory cells .(figure 3,4)

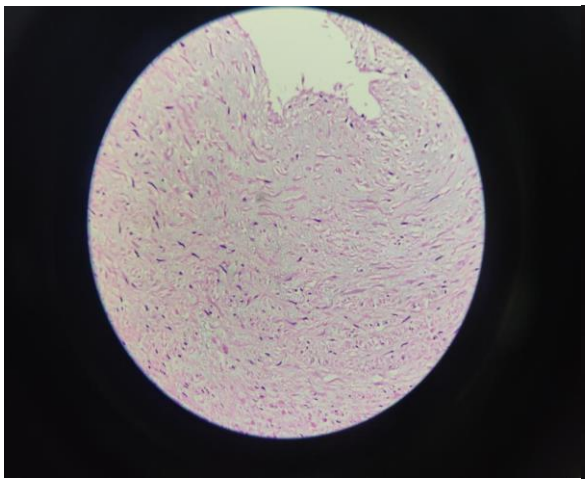

Figure 4

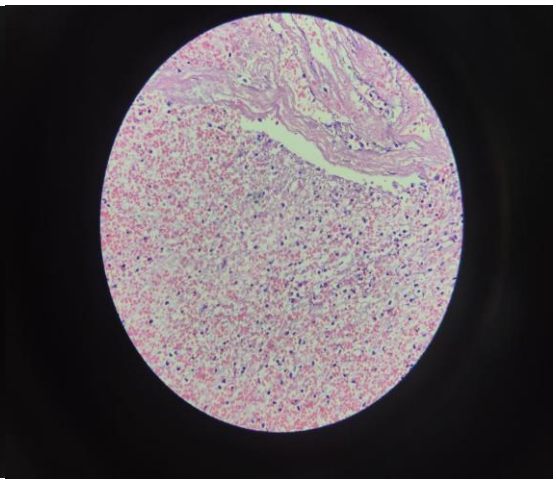

Figure 5

DISCUSSION

Retained placenta can be asymptomatic throughout pregnancy and delivery and it can only be diagnosed in post partum period. For known cases of adherent placenta it is very important to develop protocols for managing known cases of adherent placenta, obstetricians must think of retained placenta possibility with risk factors in a patients should use their clinical judgement if such case is seen.Knowledge regarding previous uterine surgeries and or complications in labor and delivery can be helpful for obstetricians for managing a suspected case of retained placenta.There are other risk factors including endometrial scarring due to endometritis, age of mother greater than 35 years, multiparous women, submucous fibroids, and embryo deposition close to the cervix during IVF [7] .It is important that in cases of PPH secondary to retained placenta right clinical judgment should be taken.If placenta accreta,increta or percreta is clearly diagnosed on ultrasound, best option would be hysterectomy with placenta in situ to reduce mortality and morbidity to mother and fetus, as attempting manual removal

of such morbidly adherent placenta is usually not successful and most of the time land up in severe post partum hemorrhage and sepsis.There is more risk of mortality to mother because of uncontrolled bleeding and DIC. Hence,it is better to perform life-saving hysterectomy rather than to wait.A 2005 prospective observational study by Magann et al. did a prospective observational study in 2005 to assess postpartum hemorrhage in women with vaginal deliveries [8.] "Using receiver operating characteristic curves, the authors showed that 95% of normal placental delivery occurs within 18 minutes and that the third stage of labor lasting longer than 18 minutes is associated with a significant risk of postpartum hemorrhage"[9].A 2012 follow-up study by Magann et al. conducted a followup study in 2012 which included a RCT assigning vaginal deliveries to manual removal at either 10 or 15 minutes (as opposed to the traditional 30 minutes) of the undelivered placenta [10.] The authors found that removal of an undelivered placenta at 15 minutes had a significantly greater likelihood of hemorrhage compared to removal at 10 minutes [10] thereby advocating for earlier intervention in the management of retained placenta. . Abnormal placentation (accreta, increta and percreta) has emerged over uterine atony as the leading indication for peripartum hysterectomy. However, these placental abnormalities rarely get detected before delivery [11–13]

CONCLUSION

Retained placenta can be a source of significant surgical and hemorrhagic morbidity and mortality to the mother. The obstetrician should have knowledge of risk factors retained placenta and morbidly adherent placenta in order to lessen maternal morbidity, also to classify those patients who are risk of hemorrhage and prepare for blood and blood products.Prompt diagnosis and management with appropriate personnel, access to blood for massive transfusion protocol, and surgical equipment such as uterine suction and tamponade can be required to treat retained placenta and lessen its morbidity.

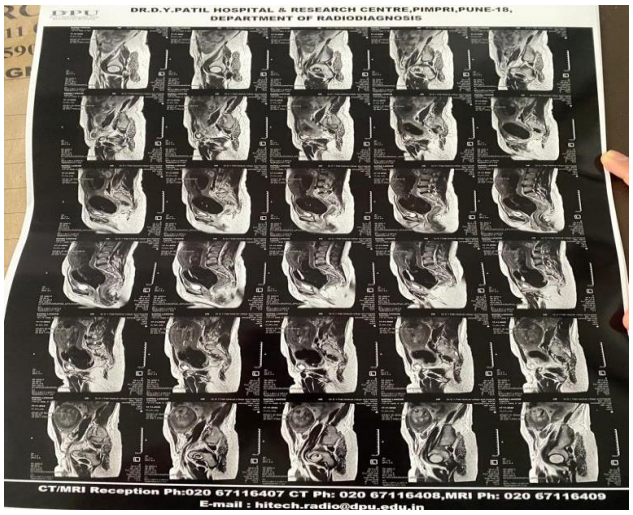

Figure 1

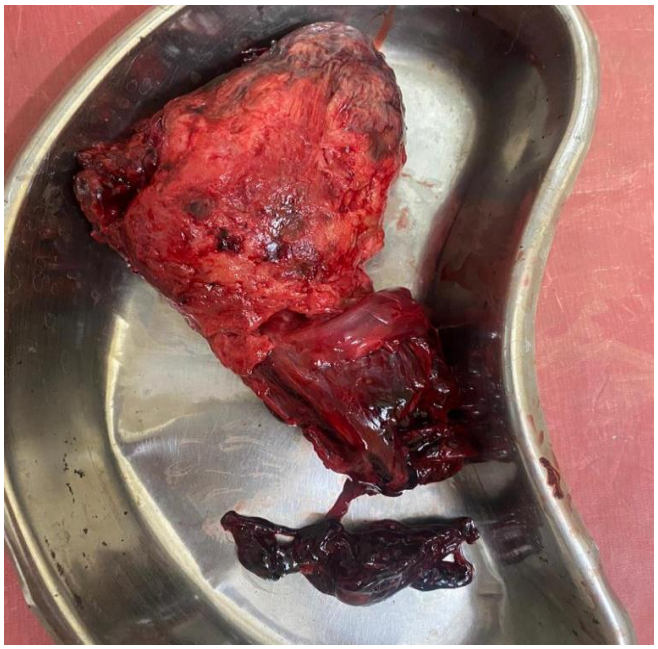

Figure 2

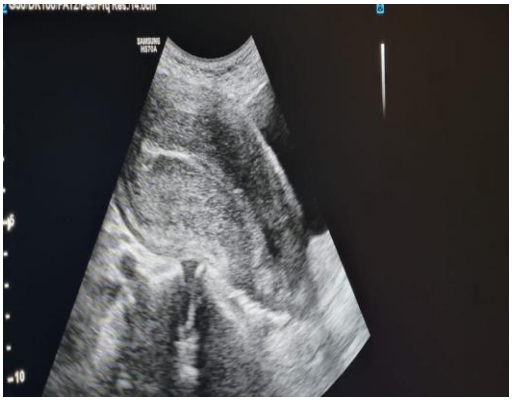

Figure 3

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