

Placenta Previa with Succenturiate Placenta—Delivered with a Living Healthy Baby

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Abstract:

The placenta is a flattened discoidal mass . Placenta with various abnormal shape like bidiscoidal, low-patiented, placenta membranacea or diffuse, placenta succenturiata, circumvallate circummarginate placentae have been less encountered but very remotely studied in relevance to clinical significance. Placenta succenturiata is a bilobbed placenta , where there is one large and one small part, connected with membranous vessels. It is associated with antepartum haemorrhage, Vasa previa, postpartum haemorrhage, retained lobe of placenta and infection. Antepartum haemorrhage due to placenta succenturiata appears to be uncommonly recorded in the literature. We describe a case of placenta succenturiata , presented with antepartum haemorrhage. By LSCS a living healthy male baby of 3.3 kgs was delivered. Ultimately the Internal Iliac arteries were ligated to stop lower uterine segment bleeding.

Keyword: Antepartum haemorrhage, bilobbed placenta, Postpartum haemorrhage, succenturiate placenta

Introduction:

The succenturiate placenta is morphological abnormality where one or multiple accessory lobes connected to the main part of the placenta by blood vessels. They appear to be associated with increase in maternal age, women with assisted reproductive technology, patient with diabetes mellitus¹. Incidence is 16-18 per 10,000 pregnancies. Depending on the position of the cotyledons and their vascular connections and association it may co-exist with vasa previa, placenta previa and retain placental tissue¹.

Case Report:

A 34 years aged third gravid P1+1 female with previous history of two vaginal deliveries has been admitted with complain of ante-partum haemorrhage for last 3 hours which was bright red and moderate in amount but not associated with pain abdomen. Her LMP was 19 April, 2014 and EDD was 26th January, 2015.

Her ultrasonographic reports were as follows—on 7.7.2014 (11 weeks 6 days gestation according to LMP) revealed a gravid uterus containing a single gestational sac with a live fetus of gestational age 10 weeks 4 days. on 27th September 2014 showed a single live fetus with no major congenital abnormality detected with low lying placenta with succenturiate lobe and gestational age 22 weeks and 2 days. on 18th December 2014 revealed single viable fetus with 33 weeks 4 days maturity and placenta was on upper anterior segment.

All the blood parameters were within normal limit. The patient was admitted with antepartum haemorrhage, but at the time of admission was haemodynamically stable with BP 130/70 mmHg, pulse 90/minute, BT 3 minute and CT 6 minutes, though pallor was present. On per-abdominal examination, uterus was term size with oblique lie and cephalic presentation, FHS was audible

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Pervaginal examination was not done, but after gentle widening of the vaginal opening a huge clot (approximately 300 ml of blood) was removed. After proper counseling of the patient attendant and taking high risk consent for LSCS, keeping in mind the isolated report of placenta succenturiata may be as a case of antepartum haemorrhage patient was sent to OT. Abdomen was opened by lower transverse incision! after proper pushing down of bladder a lower uterine transverse incision was made. Placenta was on the posterior uterine wall and was completely covering the internal os. a live baby of 3.3 kilogram was delivered by vertex. There was severe posterior uterine wall oozing. Bilateral uterine arteries were ligated, but profuse bleeding from posterior uterine wall was continuing. Bilateral Internal Iliac arteries were ligated, bleeding stopped from posterior uterine wall but uterus remained atonic and flabby. It was treated conservatively at OT and after some time uterus became firm and well contracted. The uterus was repaired in two layers, haemostasis was secured, abdomen was closed in layers. Placental examination revealed that there was two lobes of placenta—one was main lobe and other was small accessory lobe, [Fig-1]. The two were connected by communicating blood vessels traversing through the membrane [Fig-2] and the vessels remained intact.

In the post-operative period the patient had received 3 units of packed RBC and two units of FFP transfusion.



Fig-1: one main lobe and other small accessory lobe.

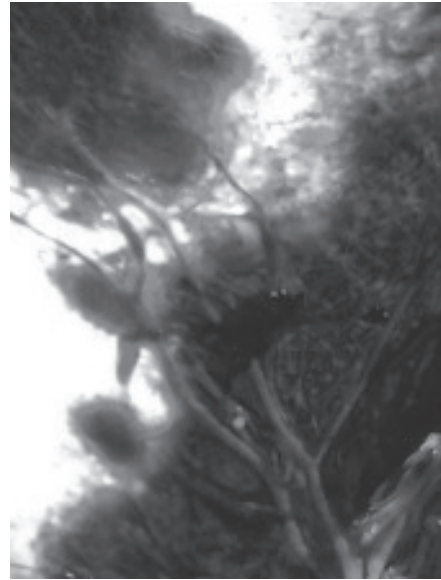


Fig-2: The two lobes were connected by communicating blood vessels traversing through the membrane

Discussion:

Placenta succenturiata is a rare variety of placenta where single or multiple accessory lobes of varying size developed in the placental membrane at a distance from the periphery of the main placental mass and connected by blood vessels. Hypothesis behind multilobbed placenta is implantation in areas of decreased uterine perfusion followed by preferential growth in areas of superior perfusion and atrophy in areas of poor perfusion. This is called trophotropism. It is encountered mostly in complicated pregnancies which might result in fetal death². The membranous vessels connecting the two lobes occasionally thrombose, rupture, become compressed, or present clinically as vasa previa with bleeding. And are associated with multiparity, antenatal bleeding, placenta previa, and retained placental tissue³ with consequent post-partum haemorrhage. Succenturiate placenta does not increase the risk of foetal anomalies⁴. The main risks of this kind of placenta occur at the time of delivery as vessels may rupture during labour causing foetal death^{5,6}. So its antenatal recognition is important. It is also associated with vasa previa (Antepartum haemorrhage), retained missing lobe of placenta, post partum haemorrhage, and infection⁴. On USG apparently separate mass of placental tissue without recognizable bridging tissues is seen as a smaller separate lobe of hyperechoic texture to the main placental disc. Amniotic band can

be separated from succenturiate placenta by colour Doppler⁷ imaging. The uniqueness of this case is that though complications to the mother and baby is much more common in pregnancy no untoward complications happened. Also, USG for three times revealed the presence of placenta succenturiata only once, which is really difficult to diagnose on routine transabdominal USG.

Conclusion:

Though succenturiate lobe may occur rarely, it should be kept as differential diagnosis of antepartum haemorrhage. It may be associated with foetal death, but live healthy full term delivery may possible. It may also be complicated by retained placental material, may lead to primary as well as secondary postpartum hemorrhage. Later on, it may lead to uterine sepsis and sub involution. Accompanying vasa praevia might cause dangerous fetal hemorrhage at delivery.

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Basic Medical Sciences Volume - II, Issue –4
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