RECURRENT PLACENTA PRAEVIA

(A Case Report)*

by

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Attention having been drawn to the rarity of recurrent placenta praevia by no less an authority than F. J. Browne, it was thought worth while to report this case which was treated at the Shree Sayaji General Hospital, Baroda. On going through the literature we were struck by the paucity of material on this condition, the only case reports we came across being of Fitzpatrick, who has recorded a case, in which it recurred five times in consecutive pregnancies, and that of A. Westgren, who has mentioned a recurrence in three patients in his study of 350 cases of placenta praevia in 10 years.

The aetiology of placenta praevia has been discussed and conjectured about time and again. Certain facts have emerged as a result of this. We know that one of the causes is low implantation of the ovum. Various reasons have been given for this, one of which is attributed to the late development of the trophoblast, so that the ovum is unable to embed itself in the decidua till it is about to escape out. Others blame the corpus luteum which is unusually slow to influence the uterine mucosa which, consequently, is not ready to receive the zygote until the latter has reached the lower pole of the uterus. Another mode of origin has been described where the decidua capsularis takes on placental formation. Normally the villi of the decidua capsularis atrophy after the third month and the placenta is formed entirely from the decidua basalis. According to this theory which was first postulated by Robert Barnes, but later fully described by Hofmeir-Meir, Kaltenbach and Clarence Webster, the capsular villi sometimes persist possibly from an abnormal blood supply, and form "A Capsular Placenta" at lower pole of the ovum which comes in contact with the decidua vera and fuses with it. Penrose carried out a statistical study of the influence of maternal age and parity on placenta praevia. The result shows the possibility of increasing age being an important factor in causing central placenta praevia, and multiparity being the chief cause in

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cases of lateral and marginal placenta praevia.

S. Bender, from Liverpool University, has suggested that the lower segment caesarean scar may predispose to placenta praevia in subsequent pregnancies, but no statistics are available as to the incidence of placenta praevia in all cases of lower segment caesarean section.

High parity as a cause of placenta praevia has been cited by many authors, but Comyns Berkeley, in his impressive series of 4406 cases, found an incidence of 20.1 per cent as being in primigravidae. We also feel that if multiparity played such a significant role in the causation of placenta praevia there should be a larger incidence of recurrent placenta praevia than has been found.

Case History

A patient named M.B.P. aged 35 yrs., was admitted in the labour room at 10-35 A.M. on 20-8-62, with a history of bleeding per vaginam for 2 hrs., previous to admission. She was a fourth para, with an amenorrhoea of 34 weeks. She had had two bouts of painless bleeding per vaginam. The first bout of bleeding started on 19-8-62 and stopped immediately. After 10 hours of this bleeding she started getting mild labour pains and whilst coming to the hospital she had the second bout of bleeding. About two diapers were soaked on the way and bleeding was present on admission.

Obstetric History

Patient — a fourth gravida and fourth para.

First F.T.N.D. at home, male baby 6 yrs. old living.

Second was a lower segment caesarean section, done for hand prolapse in 1959. No history is available as to the cause of malpresentation.

Third also was a lower segment caesarean section, done for antepartum haemorrhage on 22-4-61 at Shree Sayaji General Hospital, Baroda. Baby was a male and is living, 1½ yrs. old.

On tracing the records of this caesarean section it was found that patient was admitted on 22-4-61 with a history of recurrent painless bleeding per vaginam during the 9th month of pregnancy. She had no labour pains or bleeding per vaginam on admission. She was examined and diagnosis of placenta praevia was arrived at clinically. Five hours after admission the patient started bleeding per vaginam. There were no labour pains.

As the patient was full-term and as the history and examination suggested the presence of placenta praevia, an immediate lower segment caesarean section was performed. The placenta was found to be in the lower segment and was of the central type, covering the os completely. The patient was given a blood transfusion. There were no postoperative complications and the patient went home on the 10th postoperative day.

This time as the patient was in labour in the 9th month of pregnancy with a transverse lie of the foetus, bleeding per vaginam and foetal heart sounds were present (a history of two caesarean sections) it was decided to do an immediate caesarean section. A lower segment caesarean section, with sterilisation was done. The placenta was found to be of the central variety covering the internal os completely. There were no postoperative complications. The patient was discharged on 31-8-62.

Summary

(1) A case is reported in detail where a placenta praevia occurred consecutively in two pregnancies.

(2) No definite aetiology of placenta praevia is known but different theories of its aetiology have been enumerated. None of these theories can satisfactorily explain occurrence or recurrence of placenta praevia.

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