# HAEMANGIOMA OF THE PLACENTA

## (A Case Report)

by

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*Introduction*

We are reporting here an unusual case of a large haemangioma of the placenta and have discussed some implications of this tumour.

**CASE REPORT**

U. M., a Hindu housewife aged 23 years, registered for confinement on 29-8-1968 (in the 7th month of her pregnancy), and came for periodic check-ups thereafter to the antenatal clinic.

She was a second gravida, with a history of having delivered a healthy male child 3 years ago. The previous pregnancy and labour were uncomplicated.

At her antenatal visits, the pregnancy was found to be proceeding normally. The only abnormal finding was a slight excess of liquor amnii. The foetus was normal and growing well.

She was admitted with labour pains on 15-10-1968, (11 days after the last antenatal examination) and in the 36th week of her pregnancy. The physical findings at this time were as follows:

Blood pressure—110/74 mm. Hg. Urine —N.A.D. No oedema; no anaemia. Heart and lungs—normal. Haemoglobin—88%.

Abdominal examination revealed a mild hydramnios. The foetus was presenting by the vertex (right occipito-anterior position) and the head was engaged. The contractions were good. The foetal heart sounds were absent.

Vaginal examination revealed a cervix well taken up and admitting 2 fingers, a deeply engaged vertex, and a tense bag of membranes.

The patient delivered spontaneously after a labour lasting approximately 12 hours, a female stillborn foetus weighing 4 lbs. 6 ozs.

After the birth of the baby, the uterus still appeared unduly large, and a second, small macerated twin was thought of. A vaginal examination carried out at this time showed a soft, solid mass attached to the placenta.

After 20 minutes, the placenta delivered spontaneously and showed a purple, vascular tumour, about 5″ x 4″, on its foetal surface (Fig. 1). The weight of the tumour was 450 gm.

There was no post-partum haemorrhage and the puerperium was uneventful.

Permission for autopsy on the stillborn baby was refused.

The following investigations were carried out during the patient's hospital stay: blood V.D.R.L. and K.T. negative; blood sugar 115 mgm.%; blood urea 20 mgm.%; blood group III 'B', Rh positive; urine routine N.A.D.; vaginal swab, Gram negative bacilli were grown.

**Examination of the Placenta**

**Gross:** A single, circumscribed, capsulated mass, 13 x 12 cm., attached to the

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placenta. The cut section showed a homogeneous dark red appearance.

**Microsocpic:** The tumour showed a typical appearance of capillary haemangioma **(Fig. 2).**

*Discussion*

Haemangioma was supposed to be a rare tumour of the placenta, and was first described in 1798 by John Clarke.

Most older authors report an incidence of 1:8000 to 1:11000. There is a growing body of opinion that in fact these tumours are not so rare, and that the real incidence may be of the order of 1:100 if all placentae are systematically sliced and all slices are inspected (Shaw-Dunn 1959). These observers believe that the small tumours which have no clinical manifestations are missed when they are in the substance and not on the surface of the placenta (Fox. 1966).

Haemangiomata of the placenta may produce some interesting clinical pictures:-

(1) *Hydramnios:*

De Costa *et al,* 1956, and Wentworth, 1956, and other authors have reported a high degree of hydramnios in at least 25 to 33% of cases. Siddal (1926) observed that with large tumours (larger than a hen's egg) the incidence of hydramnios rose to 48.7% (Siddal, 1926).

It is possible that either a transudation of fluid from the surface of the tumour or compression of the umbilical vein by the tumour may cause hydramnios.

(2) *Pre-eclampsia:*

Toxaemia is supposed to be commonly associated with these tumours. Fox (1967) has worked out the incidence as 7 to 9%, which is not much higher than in the general population.

(3) *Premature labour:*

This occurs in 35% of cases of haemangiomas. Factors such as hydramnios and congenital malformation may explain the premature onset of labour.

Labour itself is usually normal except where the tumour is sufficiently large to cause dystocia (Marchetti 1939).

*Effects on the foetus:*

There is a high perinatal mortality associated with this tumour, partly due to prematurity and partly due to congenital malformations (Siddal 1926).

In many cases, particularly with large tumours (as in the present case), no other factor is found to explain the intrauterine death of the foetus. It is likely that the foetal blood is shunted through the tumour without oxygenation, and this leads to foetal anoxia and death.

The corrected perinatal mortality attributed to the tumour by Fox, 1935 is 5.5%.

The babies who are born alive are usually normal. Some have cardiomegaly, and they have an increased tendency for the formation of angiomata in the skin and elsewhere (Fox 1967).

*Summary*

A case of haemangioma of the placenta is reported, with a brief review of its clinical implications.

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*See Figs. on Art Paper III*