RETAINED ADHERENT PLACENTA
A CRITICAL EVALUATION OF CONSERVATIVE MANAGEMENT

by

G. PALANICHAMY,* M.D., (Obst. & Gynec.)

Definitive diagnosis of placenta accreta rests upon the demonstration of microscopic evidence of villi within the myometrium and the absence of a decidua basalis. However, in view of the necessity for expeditious therapy when placenta accreta is encountered, it should be looked upon not as a pathological oddity but as a clinical situation in which the placenta is retained after birth of the child and adhesions are felt at the time of manual removal. The term "adherent placenta" is preferable to denote this clinical situation. The word "accreta" is derived from the latin "accrescere" which specifically refers to "the growing together of parts that are naturally separate". It does not imply adherence. Hence the terms "placenta accreta" and "adherent placenta" should not be used synonymously. "Placenta accreta" is a pathological entity, whereas "adherent placenta" is a clinical situation.

*Assitant Professor, Department of Obstetrics and Gynaecology, Tirunelveli Medical College Hospital, Tirunelveli (Tamil Nadu).

Received for publication on 22-10-74.

Material and Methods

There were 218 cases of retained placenta managed in Tirunelveli Medical College Hospital, Tirunelveli, over a period of 6½ years from January, 1968 to June, 1974. The exact nature of these cases appear in Table I. This report is based on 138 adherent placentae. Of them only 30 were delivered in our institution and all others had delivered outside. Out of 30 patients who were delivered in this hospital, there were 9 cases of adherent placenta praevia and these cases have been reported separately.

TABLE I

Cause of Adherent Placenta

	Hospital Deliveries	Outside Deliveries	Total
Adherent	30	108	138
Not adherent, not separated	11	40	51
Separated, but retained	1	28	29

Results

Since a large number of patients were admitted after delivery elsewhere, it is very difficult to state the incidence of this complication. Among 12,032 deliveries in the hospital during the period of study, the placenta was adherent in 30 cases. This gives an incidence of 0.25%. (1 in 400 deliveries.) Fifteen patients died before treatment. In 6, abdominal hysterectomy was done. Manual removal was done in the remaining 117 cases. It

was removed piecemeal in 51 cases. Of them, 3 required a subsequent curettage. The direct causes for maternal deaths are shown in Table II. One patient was already dead when received in the Casualty Department. Twenty-one deaths occured in women who were brought into the hospital in a moribund condition. Five deaths occured in patients in whom the general condition was otherwise satisfactory. In all these cases, difficult and persistent attempts had been made to remove densely adherent placentae. The only maternal death in the hysterectomy group was also as a result of profuse haemorrhage resulting from initial attempts to remove the densely adherent placenta praevia during caesarean section.

TABLE II

Direct Causes for Material Deaths

1. Seen dead	1
2. Admitted Moribund:	
(A) Died before treatment	14
(B) Died after M.R.P.:	
a. Acute Pulmonary Oedema	1
b. Nephrotic syndrome	1
c. Cervical tear	1
d. Coagulation failure	1
e. Further shock	3
3. Haemorrhage and Shock as a result of:	
a. Difficult M.R.P.	1
b. Piecemeal removal of placenta	3
c. Caesarean hysterectomy following initial attempts to remove densely adherent placenta	1
Total	27

The maternal prognosis was unfavourable in patients who were brought with retained placenta after outside delivery. The maternal mortality increased sharply with increase in delivery-admission interval (Table III.). The outcome of management in relation to the general condition of the patient at the time of admission is shown in Table IV. Both manual removal and hysterectomy resulted in further shock in a large number of cases. One half of the patients who were admitted in a moribund condition died and the other half of these patients survived after manual removal of the placenta. In them, hysterectomy was considered to be very risky. The necessity for adequate replacement transfusion is shown in Table V. Ten patients died for want of blood. In 22 patients manual removal had been attempted outside, and 59% of them died. Acute puerperal inversion of the uterus and coagulation failure were other contributive factors to higher maternal mortality rate.

Discussion

The management of placenta accreta presents a dilemma. Irving and Hertig (1937) recommended immediate hysterectomy and this view has remained un-

TABLE III

Maternal Deaths in Relation to Delivery Admission Interval

Delivery-Admission Interval	No. of cases	Died	Incidence
Within one hour	4	0	Nil
1- 2 hours	72	12	16.7%
3-12 hours	19	5	26.3%
13-24 hours	5	2	40.0%
Over 24 hours	3	2	66.7%

TABLE IV

Maternal Deaths in Relation to General Condition of the Patient and Type of Management

G.C. on admission any Type of management.@		Total	Improved		Shocked further			
					Survived		Died	
			No.	%	No.	%	No.	%
Fair	I	64	37	57.3	23	36.0	4	6.7
	II	5	1	20.0	3	60.0	1	20.0
Shocked*	I	24	4	16.7	18	75.0	2	8.3
	II	1	–	–	1	100.0	–	–
Moribund**	I	44	4	9.0	18	41.0	22	50.0
	II	Nil	–	–	–	–	–	–

@ I. Manual Removal of Placenta II. Hysterectomy.

* Pulse over 110/minute; B.P. systolic 60 to 90 mm of Hg; Pallor±.

** Pallor present; pulse not felt or just perceptible; B.P. not recordabel or less than 60 mm of Hg. systolic.

TABLE V

Maternal Deaths in Relation to Blood Replacement

Quantity of Blood transfused	No. of cases	Died	Percent
Seen dead	1	1	–
Blood not required	40	0	Nil
Blood required, not available	19	10	52.6
350 ml	48	11	22.9
700 ml	24	4	16.7
1050-1750 ml	6	1	16.7

challenged till date. An analysis of the cases reported in the literature undoubtedly indicate that immediate hysterectomy is the ideal treatment. But there is a practical problem which has not been emphasised in the literature. Not all retained placentae are adherent, and not in all cases of adherent placenta, the adhesions are inseparable. In this study, one third of retained placentae were not adherent. The cause of retained placenta in a great majority of cases is obscure, but it is assumed that the uterine contractions are not sufficiently intense to detach the placenta. (Eastman and Hellman, 1966). Hence the sequence of events which include intravenous methergine, pitocin drip, controlled cord traction, etc. are unavoidable rituals in the management of retained adherent placenta. We could not dispense with the procedure of manual removal, which we should always attempt, at least to make sure that the placenta is inseparably adherent. It is exactly at this juncture nicety of judgement largely determines the survival of the mother. The obstetrician should know precisely when to desist from further attempts at separation. According to Rotton and Friedman, (1957), attempted manual removal is fraught with considerable danger and except for the purpose of establishing a clinical diagnosis, its use should be strongly condemned. However, we feel that mere presence of adhesion between

the placenta and the uterus does not justify a hysterectomy. If the placenta could be removed completely without difficulty it should be done to obviate a major surgical procedure. However, hysterectomy should be preferred to piecemeal removal of the placenta.

The obstetrician should be very cautious in his attempts to separate and remove the placenta. His attempt should be genuine, but nevertheless gentle too. Over enthusiastic attempts, i.e., an all out effort to remove densely adherent placenta—what may be called a radical conservatism—is perhaps the cause for many maternal deaths ascribed to conservative management. A difficult and harrowing manual removal is much more shocking and damaging than hysterectomy itself. Therefore, when a genine and gentle attempt reveals an inseparable placenta, abdominal hysterectomy should be performed without further delay.

In this study, most of the maternal deaths occured in women delivered outside and brought into the hospital in moribund stage. Many of these deaths are preventable. As pointed out by Menon (1969), these deaths are as a result of lack of co-ordination between institutional and domiciliary midwifery and absence of 'flying squad' facilities. In such cases, hysterectomy is certainly very risky and the only hope for their survival is to transfuse enough blood and to remove the placenta. In fact, 50 per cent of these patients survived after manual removal of placenta. In our study, 5 deaths are attributable to persistent attempts to remove the placenta and in one enough damage had been caused by initial attempts to separate the placenta before hysterectomy was done.

These observations certainly call for a radical change in our attitude towards the management of this clinical sutuation. Manual removal should always be attempted by a senior obstetrician. While attempting manual removal, the obstetrician should honestly resist temptation to find a non-existent plane of cleavage.

Summary and Conclusions

Retained adherent placenta has been looked upon as a clinical situation and the outcome of conservative management of this condition has been critically evaluated. Most of the maternal deaths occured in patients delivered outside and brought into the hospital in a moribund condition. Five maternal deaths were related to persistent attempts to remove densely adherent placenta. It is suggested that when a genuine and gentle attempt to remove the placenta shows dense adhesions, hysterectomy should be performed instead of persisting with an all out effort to separate the inseparable placenta.

Acknowledgement

I am thankful to Dr. B. Subbiah, M.D., DCH., Superintendent, Tirunelveli Medical College Hospital and Dr. S. Ananthalakshmi M.D., DGO, Reader and Head of Department of Obstetrics and Gynaecology, for their kind permission to report hospital records.

References

1. Eastman, N. J. and Hellman, L. M.: William's Obstetrics, ed. 13, N.Y., 1966, Amerind Publishing Co. Pvt. Ltd., pp. 947-948.
2. Irving, F. C. and Hertig, A. T.: Surg. Gynec. Obstet. 64: 178, 1937.
3. Menon, M. K.: Obstetrics in India, Modern Trends in Obstetrics No. 4, Edited by Kellar, R. J., Lodon, 1969, Butterworths, pp. 301-304.
4. Rotton, W. N. and Friedman, E. A.: Obst. & Gynec. 5: 580, 1957.