MANUAL REMOVAL OF PLACENTA

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In the third stage of labour undue interference and meddlesome midwifery can do more harm than good and the normal case in a minute becomes abnormal. "The Obstetrician's judgment must be sure and swift, and errors of commission carry with them penalties as great or greater than those of omission" (Donald, 1969). Sometimes in this stage placenta does not separate per sé, and ordinary procedures for promoting its separation and expulsion fail. Under this situation obstetrician has to do manual removal of placenta after assessing the case.

The present study deals with 320 cases of manual removal of placenta in Obstetric Department of J.L.N. Hospital, Ajmer from April 1968 to May 1975. On admission, age, parity, past obstetric history and clinical findings were recorded.

Various stages of labour, mode of delivery with associated condition and general condition at the time of operation were noted. The indications, anaesthesia and complications are discussed. Placenta was also examined for evidence of any abnormality.

Age and Parity

Majority of the patients fall in the age group of 15-30 years as this is the commonest age group attending the antenatal clinics of the Hospital. One hundred and forty were primiparas, 113 of parity 2-4, 40 of parity 5 to 7 and 27 were above parity 7. This complication is commoner in primipara as they are predisposed to prolonged labour, maternal exhaustion, uterine inertia and operative interferences.

Condition on Admission

Many of these cases were unbooked, and were brought directly from the village or after home delivery with retained placenta with or without bleeding.

Thirty-five per cent (112) of cases had moderate to severe anaemia, 20.9 per cent (67) had toxaemia of pregnancy of which 8 were admitted with eclamptic fits. 3.1 per cent of cases (10) came in the state of shock with profuse bleeding. One had the flaccid paralysis of right limb. These conditions are important as they have a bearing on the operative and post-operative well-being of the patient. Eighty, 25 per cent were normal.

Associated Condition

Table I shows that 10 patients were brought with antepartum haemorrhage. The ratio of placenta praevia and accidental haemorrhage was 1:1. Malpresentations were present in 139 cases which required operative interference leading to prophylactic removal of placenta as patients were already under anaesthesia;

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TABLE 1
Associated Conditions

Associated Conditions	Number of Patients
Placenta praevia	5
Accidental haemorrhage	5
Transverse lie	112
Breech presentation	20
Brow presentation	1
Face presentation	4
Face to pubis	1
Deep transverse arrest	1
Twins	11
Hydramnios	11
Anencephaly	1
Foetal ascitis	1
Hydrocephaly	4
Bicornuate uterus	2
Heart disease	2
Fibroid uterus	2
Uterovaginal prolapse	1
Vaginal cyst	1
Compound presentation	2

2 had congenitally malformed uterus while 2 had intramural fibromyoma of uterus.

Mode of Delivery

Out of these 320 cases 18.8 per cent (60) had normal delivery, 6.2 per cent (20) had breech delivery, 28.4 per cent (91) had forceps delivery, 31.6 per cent (101) had internal podalic version and 14.0 per cent (45) underwent craniotomy, evisceration and decapitation as shown in Table II.

TABLE II
Mode of Delivery

Mode of Delivery	Number of cases	Percentage
Normal delivery	60	18.8
Breech	20	6.2
Forceps	91	28.4
I.P.V.	101	31.6
Craniotomy	23	7.2
Evisceration & Decapitation	22	6.9
Face to pubes	1	0.3
Shoulder dystocia	2	0.6

Indications

Bruce Mayes says, "The really difficult part about manual removal is the decision to undertake it". Table III shows the indications in the present series of manual removal of placenta.

TABLE III
Indications

Indications	Number of cases	Percentage
Retained placenta	56	17.5
P.P.H.	10	3.1
R.P. & P.P.H.	11	3.4
Prophy. removal	243	76.0

Table III shows that M.R.P. was done in 17.5 per cent of cases for retained placenta. There is lot of controversy over normal duration of 3rd stage of labour and as to when it should be labelled as pathological. According to Eastman (1966) placenta should be expelled within one and a half hours after delivery of the child. There was one case of placenta accreta in the present series. According to Phaneuf (1933) the incidence of placenta accreta is 1:6,000 to 1:40,000 though Eastman (1966) in his survey of 70,000 deliveries did not come across a single case. Prophylactic removal of placenta was done in 76.0 per cent of cases (243) as these patients were under anaesthesia for some operative interference.

In 243 cases placenta was removed within half an hour as patients were under general anaesthesia due to operative procedure. In 24 cases the time lapse was half an hour to one hour, while in other 24 cases it was 1 to 2 hours. In the remaining 29 cases the time lapse was more than 2 hours because the patients were referred from far off places and villages.

In 292 cases the placenta was complete. There were 5 cases of placenta previa. One placenta was swollen and big, the

patient was also K.T. positive. Five placentae had retroplacental clots while same number of placentae were removed in pieces. One was placenta accreta while 11 placentae had calcified patches.

Table IV shows the complications which occurred in the present series inspite of antibiotics, blood transfusion, and careful attention.

TABLE IV
Complications

Complications	Number of cases
Shock	15
Haemorrhage	8
Pyrexia	4
Sepsis	6
Afibrinogenaemia	1

Fifteen cases had shock, out of which 10 were admitted in shocked condition. This is a very dangerous situation in an exsanguinated and hypotensive patient which has to be weighed against the shock induced by the longer retention of placenta. Fever and sepsis occurred in 10 cases. One case of accidental haemorrhage having anaemia had severe P.P.H. and afibrinogenaemia; and died inspite of all treatment.

Maternal Morbidity and Mortality

Sepsis occurred in cases who were unregistered, and came from villages or were anaemic with poor general health. In the present series not a single death was due to manual removal of placenta, 2.18 per cent of the patients died due to some associated conditions and it is similar to the incidence reported by Sheth *et al* (1966) i.e. 2.5 per cent. This series shows 1.25 per cent (4 cases) of cases died of atonic P.P.H. and 0.3 per cent due to afibrinogenaemia. Seven cases were of rupture uterus, out of them 2 cases died, because the rent was detected during M.R.P. In 1 case prophylactic removal of placenta was done after craniotomy for obstructed labour and patient expired before she could be transferred to operation theatre, while the other case was of previous abdominal hysterotomy. The scar gave way during normal delivery, repair of rent was done but patient expired on 21st day of operation even after energetic treatment.

Summary

Three hundred and twenty consecutive cases of M.R.P. were studied in 16,637 deliveries from 1-4-1968 to 31-5-1975 giving the incidence of 1.9 per cent but the incidence of retained placenta was found to be 0.4 per cent.

Age, parity, general condition, associated diseases, mode of delivery, indications, time lapse, complications, maternal morbidity and mortality are discussed.

It is suggested that if manual removal of placenta is properly performed in time, it is fairly safe and useful obstetric operation.

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