REVERSAL OF SECOND AND THIRD STAGES OF LABOUR

(A Case Report)

by

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It is an interesting clinical condition in which the delivery of completely separated placenta takes place before delivery of the foetus. Kobak *et al* (1941) has rightly described it as reversal of second and third stages of labour. Prolapse of placenta is its synonym used by some. It is known since 1832 when Osiander for the first time defined it. Due to its rarity Maxwell (1954) had recommended proper recording of each case. We came across 1 case during last 2 years.

CASE REPORT

Mrs. R.D., aged 35 years, 8th gravida, was admitted at Bhagalpur Medical College Hospital on 20th August 1976 at 4 P.M. with the complaints of amenorrhoea for the last 8 months, pain in the abdomen and slight bleeding per vaginam for the last 6 hours. She had 7 term deliveries at home. Age of the last child was 2 years. Her menstrual cycles were regular and she had her last menstruation in the end of December, 1975. She had sudden rupture of membranes at 12 noon which was followed by pain in the abdomen. The approximate amount of liquor drained was 8000 ml. She never had antepartum haemorrhage during this pregnancy.

On examination the general condition was good, pulse was 94 per minute and blood pressure was 130/80 mm of Hg. The cardiovascular and respiratory systems were normal. On abdominal examination the uterus was 32 weeks in size with cephalic presentation; head was engaged and the foetal heart was not audible. Uterine contractions were occurring regularly at the interval of 5 to 7 minutes. Vaginal examination revealed the whole placenta lying outside the introitus with attached cord. There was no pulsation in the cord. The cervix was fully dilated and taken up, station of head was at the level of ischial spines. There was no alarming bleeding. At 5 P.M. the delivery of foetal head took place but further descent was arrested. Reassessment was done under sedation with Morphine and the foetal abdomen was found to be very much enlarged and cystic. Gentle traction helped in delivery of the whole foetus and it was a case of foetal ascitis with omphalocele (vide photograph). There was no post partum haemorrhage.

Postmortem examination of the foetus was done and the following points were noted. It was a female foetus, weight was 2 kg 400 gms and the crown-rump length was 45.5 cms. Girth of the abdomen at the level of umbilicus was 39 cms, girth of chest was 28 cms, circumference of head was 30 cms, length of each upper limb was 15 cms and that of each lower limb was 17 cms. There was a big omphalocele size of about 8 × 8 cms. The fingers were very short and webbed. All the internal organs were found to be normal on gross examination and on histology too. 500 ml of ascitic fluid was present. The placenta weighed 350 gms. It had multiple white infarcts. The umbilical cord was 48 cms in length and was attached to the placenta at its centre. The patient was discharged on the 3rd day.

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Discussion

Prolapse of placenta is a rare clinical entity. It is not a dangerous condition like placenta praevia in which the placenta is partially separated and is liable to cause haemorrhage. Some cases of placenta praevia do come with complete detachment and prolapse of placenta. Once the placenta is completely separated bleeding stops. To explain this, several aetiological factors have been put forward. Osiander considered placenta praevia as an antecedent to prolapse of placenta. Simpson reviewed 141 cases of separation of placenta before the birth of the foetus. The bleeding practically stops after complete separation of the placenta and the maternal mortality is five times less in prolapse of placenta than in placenta praevia. But this is not always true. There are reported cases where placenta was implanted in the upper segment but due to some reason or other was completely separated and presented before the foetus.

Antepartum haemorrhage is not a regular feature in prolapse of placenta. There was no APH in a case reported by Palanichamy (1976). Rucker (1926) had commented interestingly that though the placental detachment is from upper segment features of accidental haemorrhage are not usual. According to Kobak the placenta gets detached on account of sudden reduction in the endometrial surface due to (a) rapid drainage of liquor amnii in hydramnios and (b) after the delivery of the first twin. In our case too there was no APH and sudden leak of liquor amnii could explain the cause. Unusually short cord and external version have also been blamed by some.

Foetal prognosis is very grave for obvious reasons. Sometimes there is a long gap between the delivery of placenta and expulsion of foetus. In our case the interval was only one hour. In the present case, there were abnormalities like hydramnios, reversal of 2nd and 3rd stages and foetal ascitis with omphalocele.

Summary

A case of prolapse of placenta with reversal of 2nd and 3rd stages of labour in a grand multipara has been presented. The probable aetiology was drainage of liquor amnii in hydramnios leading to sudden reduction in the endometrial surface. Multiple congenital malformation in the foetus were associated.

References

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See Fig. on Art Paper III