

RETAINED PLACENTA

(Ten Years Study)

by

Mrs. P. H. ATTAL,* M.D.

and

Miss V. D. SHASTRAKAR,** M.D.

Introduction

Common cause of third stage haemorrhage is retained placenta and other secundities. This accounts for one quarter of deaths from obstetric haemorrhage as antepartum haemorrhage, ectopic pregnancy and ruptured uterus.

In recent years, maternal mortality has been considerably reduced as a result of good antenatal care, confinement in a well equipped institution, easy availability of blood and introduction of antibiotics. This fall is marked for puerperal sepsis and toxæmia but the mortality from third stage haemorrhage has not been proportionately reduced. Retained placenta remains a major cause of death in third stage.

In India, the figure for maternal mortality from well equipped hospitals are comparable to those from Europe and America. On the whole the figure for maternal mortality and morbidity is still high because of inadequate facilities in rural areas; poor antenatal care and widespread nutritional deficiency anaemia;

and they cannot reach the well equipped hospitals in time.

The causes of simple retention of placenta are avoidable if proper care is taken right from the antenatal period. Therefore, the knowledge regarding the proper management of retained placenta is important to reduce the maternal mortality.

The present survey of retained placenta over 10 years i.e. from January 1971 to December 1980 is undertaken with an aim to see the other factors, in a large hospital like ours where many abnormal cases are referred from different interior places.

Material and Methods

In the present study the cases of retained placenta in 10 year period from January 1971 to December 1980 in Government Medical College and Hospital are studied. The diagnosis of retained placenta was made mainly by history, clinical examination, excessive haemorrhage in the third stage and signs of placental separation in both booked and emergency cases.

To ascertain the probable aetiological factor of retained placenta, past history regarding previous curettage, manual removal of placenta, caesarean section, myomectomy and history of post abortal

*Reader in Obstetric and Gynaecology, Government Medical College, Nagpur.

**Professor and Head of the Department of Obstetric and Gynaecology, Government Medical College, Nagpur.

Accepted for publication on 12-5-81.

and puerperal infection, medical termination of pregnancy was taken.

The diagnosis of the type of the placenta, such as simple retained, simple adherent or invasive placenta was made during management of the retained placenta by noting whether the placenta was already separated, easily separated with the presence of a plain of cleavage or presented a difficulty in separation suggesting placenta accreta.

Abnormalities of placenta and type of invasive placenta for example placenta accreta, placenta increta and placenta percreta, complete, partial and focal varieties were all diagnosed by macroscopic examination of the removed placenta or during hysterectomy.

Observations

During the 10 years period from January 1971 to December 1980 there were 56,051 vaginal deliveries and these included 290 cases of retained placenta. The incidence of retained placenta in hospital cases was found to be 1 : 348 deliveries. The incidence of retained placenta was found to be 0.01, 0.15, 0.10, 0.15, 0.32, 0.43, 0.33, 0.38, 0.28, 0.41 from 1971 to 1980 respectively which clearly indicates successive increase over the years of the study.

Out of 290 cases, 161 cases delivered in the hospital, while 129 deliveries were outside. Most of these cases belonged to low and middle socio-economic status. In these 114 cases (39.3%) gave history suggestive of previous trauma to the endometrium. Out of these, 57 cases (50%) gave history of previous interference in the form of MTP D and C and evacuations; 26 cases (22.8%) had previous manual removal of placenta; 9 cases (7.9%) of previous caesarean section, and 22 cases (19.2%) of 'others' which in-

cludes still births, premature births and previous instrumental deliveries. Out of 161 hospital cases, 87 delivered naturally while 15 cases by forceps and 6 cases by breech. Majority of patients delivered outside did not give confirmatory history regarding mode of delivery.

Uterine anomalies discovered, like arcuate uterus, sub-septate uterus and accessory horn were found in 15 cases (5.1%) during manual removal of placenta.

Out of 290 cases, placental anomalies were found in 18 cases (6.2%) in the form of placenta succenturiata in 7 cases (38.8%), velamentous insertion of cord in 4 (22.2%), bilobed placenta in 3 cases (16.6%), placenta membranacea in 3 cases (16.6%), battledore insertion of cord in 1 case (5.5%).

Sixteen (5.5%) out of 290 retained placenta were of invasive variety. Among which 13 were of placenta accreta type (81.2%) out of which 1 was of placenta praevia accreta and 3 placentae were of increta type (18.7%). Maternal complications in pregnancy were found in 94 cases (32.1%), which comprised severe anaemia in 53 cases (56.3%), pre-eclamptic toxæmia in 29 cases (30.8%), hydramnios in 3 cases (3.2%), multiple pregnancy in 7 cases (7.4%) and placenta praevia in 2 cases (2.1%).

Duration of labour was known in hospital delivery cases. Twelve cases (7.4%) were of prolonged labour, 7 primiparae and 4 were multiparae, while duration of labour was not exactly known in outside deliveries. Hypotonic uterine inertia as a cause for retention of placenta was found in 100 cases (34.4%), out of which in 56 cases (56%) placenta was separated but lying free in uterine cavity while in 44 cases (44%) placenta was not separated. In 8 cases placenta was separated but con-

striction ring was the cause for retention of placenta.

Adherent placenta, was the cause in 192 cases (66.2%) out of which 166 cases were (86.6%) simple adherent placenta, 13 cases (6.7%) were of placenta accreta and 3 were (1.5%) of increta type.

Site of placental attachment as observed during manual removal of placenta was as below. Fundus 24.4%, anterior wall 21.7%, posterior wall 17.1%, cornua 14.4% and in 64 cases placenta was separated and lying free in uterine cavity.

Blood loss below 500 ml was seen in 7.2% in outside deliveries and in 39.3% in hospital deliveries. Blood loss above 500 ml producing moderate to severe degree of shock was seen more in outside deliveries i.e. in 37.2% as against 16.2% in hospital deliveries. Blood loss in present study was approximately estimated by clinical observation and history given by the patient.

In the present series, main cause of morbidity observed was febrile puerperium in 29 cases. Out of these 5 cases had positive vaginal swab for *E. coli* and in 1 case patient had jaundice. There were 4 deaths in the whole series giving the incidence of 1.3%. Out of these 4, 2 were in burn cases admitted with 92% and 55% burns-endotoxemic shock after hysterectomy in 1 case and other died of anaemia.

In 8 cases (2.7%) constriction ring was the cause for retention of placenta. Out of these, 2 patients delivered at home by untrained person while 6 cases delivered in hospital and received intravenous injection ergometrine at the birth of anterior shoulder, which is the routine practice in the hospitals now-a-days. Tampan *et al*

(1955) has reported 7 cases (2.2%) of constriction ring causing retained placenta out of which six cases were due to intravenous administration of ergometrine.

Various complications of retained placenta as stated by Ray (1955) were shock, acute inversion of uterus, puerperal infections and rarely Sheehan's syndrome. Rupture of the uterus while attempting the removal of placenta percreta has been reported by Shah *et al* (1973). But in present study shock and puerperal infection were the only complications encountered.

Summary

The study of 290 cases of retained placenta was carried out over 10 years i.e. from January 1971 to December 1980. Out of these, 161 cases were hospital deliveries while 129 cases from outside thus giving incidence of 1 in 348 in hospital cases. Incidence is gradually increasing over these years. Important etiological factors for retained placenta are investigated and discussed.

Acknowledgements

Authors are thankful to the Dean, Government Medical College and Hospital, Nagpur for permitting us to use hospital data and publishing this article.

References

1. Francis, O.: J. Obstet. Gynaec. India, 6: 187, 1955.
2. Ray, H. N.: J. Obstet. Gynaec. India, 6: 7, 1955.
3. Shah, J. J.: J. Obstet. Gynaec. India, 23: 191, 1973.
4. Tampan, R. K. K.: J. Obstet. Gynaec. India, 6: 15, 1955.