RETAINED PLACENTA: A CLINICAL STUDY

by

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Introduction

Some 15 years back Sheth *et al* (1966) have stated that "the most satisfying, relaxing and happiest stage in a woman's life is the third stage of labour which if it turns abnormal can be devastating and dangerous". The conclusion holds true even now inspite of so many developments in the field of obstetrics. Many complications are associated with third stage of labour, and one of the important out of these is retained placenta. The present study was done to evaluate and analyse various aspects of the cases of retained placeta.

Material and Method

The present study is based on the study of 52 cases of retained placenta at Zanana Hospital, Udaipur attached to R.N.T. Medical College, Udaipur from January, 1979 to December, 1980. During this period there were 7944 deliveries giving an incidence of 0.65%. Out of these 52 cases, 10 were booked and 42 were emergency, 14 were urban and 38 were rural.

Age: Most of the cases 63.46% were between 20-30 years of age.

Parity: Retained placenta was common in para 0 (42.3%) as compared to other cases as shown in Table I.

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TABLE I
Parity Distribution

Parity	No. of cases	Percentage
0	22	42.3
1	7	13.46
2	5	9.61
3	7	13.46
4	4	7.69
5 and above	7	13.46

Associated Factors: In 10 of the cases there were some associated factors which could be responsible for retension of the placenta (Table II).

TABLE II
Associated Factors

Associated factors	No. of cases
Bicornuate uterus	1
Arcuate uterus	1
Past H/O M.R.P.	1
Past H/O M.T.P.	1
Past H/O caesarean section	1
Placenta praevia type II	1
H/O premature rupture of membranes	4

Mode of Delivery: Thirty-three cases were admitted as home delivered, while 19 had delivery in the hospital. There was spontaneous vaginal delivery in 48 cases, outlet forceps application in 3 cases, and assisted extended breech delivery in one of the cases.

Hours of Retension of Placenta: In 24 cases the placenta was retained for more

than 5 hours after delivery. In hospital delivered cases minimum retension time was 30 minutes, while maximum was 1 hour 45 minutes. In comparison to that home delivered cases were brought as late as 40 hours (Table III).

TABLE III
Hours of Placental Retension

Hours of retension	No. of cases	Percentage
Less than 1	10	19.23
1- 5	18	34.61
5-10	10	19.23
10-24	12	23.07
24-40	2	3.84

Mode of Placental Delivery: Manual removal of placenta was required in 78.84% cases. It was done under general anaesthesia in 38 cases, and under I.V. Calmpose (20 mg.) in 3 cases. In 9 of the cases, the placenta was found lying in the vagina at the time of initial vaginal examination and hence it could be taken out without much of problem (Table IV).

TABLE IV
Mode of Placental Delivery

Mode of Placental delivery	No. of cases	Percentage
Lying separated in vagina	9	17.3
Manual removal of placenta	41	78.84
Hysterectomy (PI Accreta)	1	1.92
Expired before treatment	1	1.92

Maternal Mortality: There were 3 deaths 5.76% in the present series. All were unbooked, badly handled cases with severe anaemia. Two of them were primigravida, while 1 was a 7th gravida. The admission death interval was 2 hours in 2 cases and 5 hours in 1 case.

Maternal Morbidity: The overall incidence of shock in this series was 48%. Already existing anaemia, with malhandling and haemorrhage, worsened the clinical picture in most of these cases. In all, about 100 units of blood transfusions were arranged for these 52 cases of retained placenta. Although most of the cases were potentially infected, frank septic manifestations were noted in 25% of the cases as shown in Table V.

TABLE V
Maternal Morbidity

Complication	No. of cases	Percentage
Shock	19	36.53
Present on admission		
Shock developed during M.R.P.	6	11.53
P. sepsis	9	17.30
Peritonitis	3	5.76
Thrombophlebitis	1	1.92

Discussion

The incidence of retained placenta (0.65%) in this institution is high when compared to figures reported by other authors e.g. Gupta and Mishra (1977) as 0.4%, Sheth *et al* (1966) 0.33%, Aaberg and Reid (1945) 0.47%.

As many as 63.46% cases of this series were home delivered and were brought to the hospital after efforts at home to detach the placenta failed. Twenty-four out of 52 cases were brought after waiting for more than 5 hours. Aaberg and Reid (1945) received most of the cases within 2 hours of delivery (64.5%), and Sheth (1966) received 68 out of 72 cases within 4 hours of delivery. The more time interval between delivery and admission is not only due to handling at home but also due to long distances and lack of transport facilities.

Though there is lot of controversy regarding duration of third stage of labour, most of the obstetricians are of the view that 1 hour should be considered as maximum time limit for placental delivery. Sheth (1966) stated that if placenta is allowed to retain for more than 1 hour it predisposes to shock and under that state operation worsens the situation. In the absence of bleeding, practice is to start preparation for operation if 30 minutes have elapsed. Similar practice is observed in this institution also for hospital delivered cases. Regarding emergency cases the practice is to start treatment for recovery of shock of the patient first and then to do M.R.P., as practically all of the cases are anaemic, malnourished and are admitted either already in shocked condition or on the verge of going in shock.

There was 1 case of placenta accreta in this series (1.9%) Aaberg and Reid (1945) reported a very high incidence of placenta accreta 11% in their study of 217 cases. Gupta and Mishra (1977) had 1 case out of 320 cases studied, while Sheth (1966) had no such case while reporting study of 200 cases.

Summary

Fifty-two cases of retained placenta were studied in 7944 deliveries from January, 1979 to December, 1980, with an incidence of 0.65%. Factors like age, parity, associated factors, mode of delivery management of the case and maternal mortality and morbidity were studied.

Conclusion

There is need to educate the TBA. regarding importance of IIIrd stage of labour, the various complications associated with it, and timely shifting of the case to a well equipped institution. Where skillful handling of the case may save many of the complications and death in most of these cases.

References

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