RETAINED PLACENTA

P. K. SHAH, S. N. TANDON, S. N. PANDIT and P. R. VAIDYA

SUMMARY

This is a retrospective study of 84 cases of retained placenta, out of total 42763 deliveries, managed by manual removal of placenta. The incidence of retained placenta being 0.2 percent. 66-86 percent patients were between the age group of 20-25 years. 40.48% of primiparas and 42.8% of second paras required M.R.P. 48.81% patients had home delivery. 90.48% patients had vertex presentation.

21.43% of patients gave history of M.T.P., 14.29% of patients had previous curettage. 5.95% of patients had undergone L.S.C.S. during previous pregnancy. 10.71% of patients were administered Inj. Methergin before delivery of placenta. 8.33% of patients had antenatal anemia, 7.14% had toxomia of pregnancy and 2.38% had incomplete central placenta paevia.

92.86% of patients required general anaesthesia for M.R.P. 63.10% of patients had simple adherent placenta whereas in 34.52% of cases, the placenta was found to be separated but retained in the uterine cavity. 66.66% of patients required blood transfusion. 9.52% of patients developed puerperal sepsis.

INTRODUCTION

Retained placenta is one of the complications of third stage of labour, which in majority of cases can lead to more dangerous condition of post-partum haemorrhage. Retained placenta is one of the causes of increased maternal morbidity and mortality, particularly in developing countries like ours where home deliveries are still so common. The present study was carried out to evaluate and analyse various aspects of retained placenta.

L.T.M.G. College, Sion, Bombay.

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MATERIAL AND METHOD

The study includes 84 cases of retained placenta, managed by manual removal of placenta at L.T.M.M. College and L.T.M.G. Hospital, Sion, Bombay, from January 1982 to December 1988. There were 42763 deliveries during this period.

All the cases in which the placenta did not deliver by usual methods within 30 minutes of delivery of foetus were considered as " Retained Placenta". Detailed history taken from the viewpoint of obtaining probable etiological factor, general and clinical examination were carried out in all cases. Approximate blood loss was estimated in hospital delivery patients. Various type of retained placentae were ascertained at the of manual removal of placentae.

OBSERVATION

Incidence : THe incidence of retained placenta was 0.2%

Age distribution : Table I shows age distrubution in 84 cases.

TABLE I

Age Distribution

Age in years	No. of cases	Percentage
<19	7	8.33
20-25	56	66.66
26-30	6	7.14
>31	15	17.86

Parity ditribution : Table II shows distribution of parity in 84 cases of retained placenta.

TABLE II

Parity Distribution

Parity	No. of cases	Percentage
1	34	40.48
2	36	42.86
3	8	9.52
4 or more	6	7.14

Significant Past History and Probable Etiological factors : Table III shows the risk factors probably responsible for retained placenta in 38 (45.24%) cases out of total 84 cases.

Some of the patients had more than one risk factor present and hence the disparity in number.

Mode of delivery

Out of 84 cases 41 i.e. 48.81% had home delivery, 15 (17.86%) were transferred from other hospitals, and 28 i.e. 33.33% had delivered in our institution. 73 (86.9%) patients delivered spontaneously vaginally, 5 had as-

TABLE III

Risk factors (1)	No. of cases (2)	Percentage (3)
Past H./O. M.T.P.	18	21.43
Past H./O. Curettage	12	14.29
H/O Administration of inj. Methergin	9	10.71
Past H/O C. Section	5	5.95
Detached umbilicalcord	3	3.57

(1)	(2)	(3)
H/O Burns with preterm labour	2	2.38
Placenta previa	2	2.38
H/O Prolonged labour	2	2.38
H/O I.U.F.D.	2	2.38
Arcuate uterus	1	1.19
R.O.M. for >24 hours	1	1.19

sisted breech delivery, 3 required outlet forceps delivery,2 were delivered by induction of labour with extra amniotic Ethacridine lactate instillation for I.U.F.D. and of patient had to undergo emergency caesarean section.

Hours of retension of placenta

Table IV shoes hours of retension of placenta in 84 cases. In hospital delivery cases, the minimum retension time was 30 minutes and maximum time was 2 hours. Whereas in home delivery and transfer cases minimum retension time was 2 hours and maximum time was 18 hours.

TABLE IV

Hours of Placental Retension.

Hours of retension	No. of cases	Rercentage
1	28	33.33
1-6	48	57.14
7-12	6	7.14
13-18	2	2.38

Associated maternal complications of pregnancy

Out of 84 cases, 7 (8.33) mothers had mild to moderate anaemia during pregnancy, 6 (7.14%) had pre-eclampsia, 2 (2.38%) had marginal placenta previa diagnosed on ultrasonography and one (1.1%) had twin delivery.

Mode of placental delivery

Manual removal of placenta was done in 78(92.86%) patients under general anaesthesia and in 6(7.14%) under intravenous sedation.

The type of placental retension

Table V shows different types of placental retension in utero, at the time of M.R.P.

TABLE V

Type of placenta

Type of Placenta	No.of cases	Percentage
Separated but ratained	29	34.52
Simple adherent	53	63.10
Placenta accreta	1	1.19
Placenta increta	0	–
Placenta percreta	1	1.19

In our series there was one case of placenta accreta following 8% burns, which required piece-meal removal of placenta and curettage.In the case of placenta percreta found at the time of caesarean

section,sigmoid colon was involved and repair of rent in uterus was not possible requiring caesarean hysterectomy.

Blood loss and Blood Transfusion

Excessive blood loss producing hypovolaemic shock was seen in 21 (37.5%) out of 56 cases of home delivery and cases transfered from other hospitals. Whereas in hospital delivery cases 6(21.42%) out of 28 went into hypovolaemic shock. A total of 64 units of blood was required to be infused in 56 (66.66%) patients.

Maternal Morbidity

27 (32.14%) patients went into hypovolaemic shock due to post partum haemorrhage. 8(9.52%) patients developed puerperal sepsis. Gaping Episiotomy required resulting and prolonged stay in hospital in 2 cases).

Maternal Mortality

There were 2 (2.38%) maternal deaths out of 84 cases of retained placenta. Both were unbooked cases. One was third para, having home delivery and admitted with hypovolaemic shock. She died despite all resuscitative measures to save her life within 1 hour of admission. The other one was a case of 80% burns who died (6 days after M.R.P. of septicemia and renal failure.)

DISCUSSION

The incidence of retained placenta in this institution was 0.2%. The incidences reported by other authors are Mishra, Gupta(1977) 04%, Sheth (1966) 0.33%, Aaberg and Reid (1945) 0.47%, Mathur (1984) 0.64% and Attal Shashtrakar (1984) 0.29%.

48.81% cases were of home delivery. Mathur (1984) reported 63.46% cases of home delivery. In this series most of the patients i.e. 90.47% were received within 6 hours of delivery. Aaberg and Reid (1945) received most of the cases (64.5%) within 2 hours of delivery. Sheth (1966) received 68 of 72 cases within 4 hours of delivery. The important factors in delay in receiving these patients seem to be inadequate transport fascilities and long distance to be travelled by the patients. 1.19% of patients had placenta accreta. The incidence of placenta accreta in Aaberg and Reid's series (1945) was 11%, in Sheth's (1966) series there was no case of placenta accreta and in Mathur's series (1984) it was also 1.9%.

Maternal mortality in this series was 2.38%. It was 5.76% in Mathur's series (1984) and 1.3% in Attal shashtrakar's(1984). o73 Unlike in shah's series (1973) there was no case of rupture of uterus while attempting M.R.P. Ray (1955) had reported a case of inversion of uterus.

CONCLUSION

In the third world countries like ours, retained placenta as one of the complication of third stage of labour, is still an important causative of maternal morbidity and mortality. Proper antenatal and intranatal care of "at risk patients" would definitely help reduce such complications. Educating women about advantages of hospital delivery, better transport fascilities and timely transfer of such cases to major institutions would go a long way in reducing maternal morbidity and mortality in such cases.

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