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Retained Placenta: A Clinical Study

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Summary

Fifty two cases of retained placenta were studied in 7944 deliveries from January 1997 to December 1999, 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.

Introduction

Some 28 years back Sheth (1966) 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". This holds true even now. 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 the various aspects of the cases of retained placenta.

Material and Method

The present study is based on the study of 52 cases of retained placenta at Sub-Divisional Hospital, Durgapur from January 1997 to December 1999. 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.

Parity: Retained placenta was common in Para 'O' (42.3%) as compared to other cases shown in table I.

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

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
5 and above	7	13.46

Table II
Associated factors

Associated Factors	No. of Cases
Bicornuate	1
Arcuate uterus	1
Past H/O MRP	1
Past H/O MTP	1
Past H/O caesarean section	1
Placenta praevia type II	1
H/O Premature rupture of membranes	4

Mode of delivery: Thirtythree cases were admitted following home delivery, while 19 delivered in the hospital. There was spontaneous vaginal delivery in 48 cases, outlet forceps application in 3 cases and assisted extended breech delivery in 1 case.

Hours of retention of placenta: In 24 cases the placenta was retained for more than 5 hours after delivery. In hospital delivered cases minimum retention 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) after delivery.

Table III
Hours of placental retention

Hrs. of retention	No. of cases	Percentage
1	7	13.46
2	5	9.61
3	7	13.46
4	9	17.3
5 and above	24	46.15

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 IV 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). One patient had hysterectomy for placenta acreta while 1 died before any treatment could be given.

Table IV
Mode of placental delivery

Placenta delivery	No. of cases	Percentage
Lying separated in vagina	9	17.3
Manual removal of placenta	41	78.84
Hysterectomy (P1. Acreta)	1	1.52
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 primigravidae, while one 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 given to these 52 cases of retained placenta. Although most of these cases were potentially infected, frank septic manifestations were noted in 25% of the cases as shown in Table V.

Table V
Maternal morbidity

Complications	No. of Cases	Percentage
Shock present on admission	19	36.53
Shock developed during MRP	6	11.53
P. Sepsis	9	17.30
Peritonitis	3	5.76
Thrombophelebitis	1	1.92

Discussion

The incidence of retained placenta (0.65%) in this institution is high when compared to that reported by other authors viz Gupta & Mishra (1977) as 0.4%, Sheth (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 greater 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 from shock first and then do MRP, 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 accrete in this series (1.9%). Aaberg and Reid (1945) reported a very high incidence of placenta acreta viz 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.

Conclusion

There is need to educate the TBA regarding importance of third 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 the cases.

References

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