J Obstet Gynecol Ind Vol. 53, No. 2 : March /April 2003 Pg 190-191

Retained Placenta – A Dilemma

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Key words : placenta increta, methotrexate

Introduction

Abnormal placentation is associated with increased maternal morbidity and mortality. Severe haemorrhage can be life threatening and often a hysterectomy is required. Since this inevitably leads to loss of fertility, a conservative approach is desirable. We present a case of placenta increta, treated expectantly with methotrexate, thus avoiding a hysterectomy.

Case Report

Mrs N.G. a 26-year-old primigravida with 29 weeks of gestation and jaundice due to hepatitis came on 2nd Feb 2001. She had a pre-term delivery on the same day and a male child weighing 1.3 kg was delivered. The placenta was retained and after expectant management manual removal of placenta was tried under general anaesthesia, which was unsuccessful.

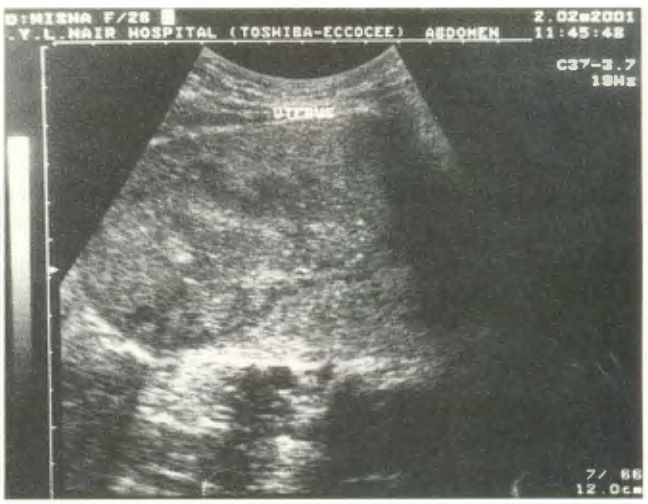
On examination her vital parameters and RS / CVS were normal. On abdominal examination uterus was well contracted corresponding to 18 weeks size. On speculum examination no active bleeding was present. On vaginal examination os was found one finger open.

Since she was a young primi gravida and no bleeding was present a decision for conservation of the uterus avoiding hysterectomy by giving injection methotrexate for resorption of the placenta was taken. Her investigations on day 2 of the delivery were Hb – 10.9 gm%., TC – 39300. serum bilirubin – 3.6 mg%. Injection methotrexate was with held due to raised bilirubin. Repeat investigations on day 5 of delivery were Hb-10.1 gm%, TC – 15300, serum bilirubin 2 mg%. βhCG 3250 miu per ml. USG showed a retained placenta with absent sonolucent area between the placenta and uterine wall suggestive of placenta increta (Photographs 1 and 2). MRI showed placenta-increta with placenta invading the myometrium and thinning of the myometrium.

Injection methotrexate 1mg per kg intramuscular in a total of three doses on alternate day was given. Folinic acid 0.1 mg per kg IM alternating with methotrexate with a total of three doses was given. Repeat USG showed increased echogenicity (Photograph 2) and colour doppler showed decreased vascularity. Patient was alright for one week after methotrexate and her repeat Hb and WBC count were normal and her βhCG was 96 miu/ml. She was discharged and asked to come for follow up if bleeding or pain occur or if she passes a fleshy mass. She passed a fleshy mass with colicky and crampy pain at home four months after delivery and reported for follow up. She had no bleeding. USG showed empty uterine cavity.

Discussion

Columbus first coined the term placenta, which meant a



Photograph 1 : Showing a retained placenta with absent sonolucent area between the plaenta and uterine wall suggestive of plaenta increta.

Paper received on 22/10/01 ; accepted on 29/1/02

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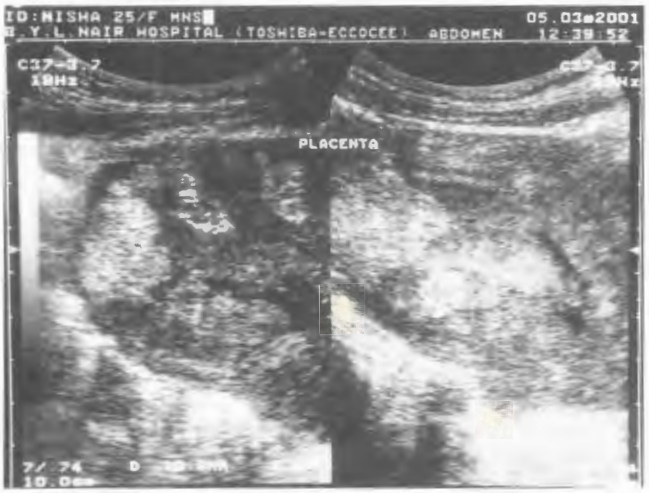

Photograph 1 : Repeat USG showing increased echogenicity

circular cake in latin. It was William Hunter who first described the term decidua and Nitabuch's layer of fibrinoid necrosis, defect in which is responsible for placenta increta.

Incidence of placenta increta is 1 in 2500 to 1 in 7000 deliveries. Arul Kumaran et al[1] first reported the successful treatment of placenta accreta with methotrexate. They used 300mg of intravenous methotrexate and 36mg of folinic acid and there was no placenta found two weeks after treatment displaying their success. Raziel et al[2] have reported successful treatment with methotrexate in a case of placenta accreta who was previously treated for Asherman's syndrome. Complete resolution occurred in a week.

Legro et al[3] did hysteroscopy eight months following administration of methotrexate which revealed an area of hyalinisation and calcification, and the woman had a normal uncomplicated delivery two years later.

In our case, since the patient was young, not bleeding and hemodynamically stable and since neonatal prognosis was uncertain, methotrexate was considered appropriate treatment.

Unless a life threatening haemorrhage occurs, a conservative approach is recommended even in a woman who does not want to preserve fertility in view of the morbidity associated with hysterectomy.

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