LITURGICAL (NOT SURGICAL) REMOVAL OF PLACENTA: A CASE OF SPONTANEOUS EXPULSION OF PLACENTA ACCRETA

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ABSTRACT The retained placenta is a significant cause of maternal mortality and morbidity throughout the developing world. It complicates 2% of all deliveries. This is a case of a 25 year female patient who came to our institute with retained placenta. The patient gave history of delayed expulsion of placenta after delivery in her previous pregnancy. An ultrasonography was performed which subsequently suggested placenta increta with the placenta being attached over a 5 cm surface of the endometrium. An informed decision for obstetric hysterectomy was made on the day of admission. The surgery was postponed by a day, until the necessary financial arrangements could be made by the relatives. However, few hours before the scheduled surgery, the patient started complaining of painless passage of clots and on examination, the placenta was felt in the vagina after voluntary separation. Consequently, the patient delivered a bilobed placenta spontaneously. In our case the placenta was delivered spontaneously within 48 hours of delivery without any external aid reinstating that in a case of retained placenta, with the due risk of infection, in the absence of per vaginal hemorrhage, spontaneous separation of placenta could be awaited in low risk cases.

KEYWORDS retained placenta, placenta accreta, placenta increta, spontaneous expulsion

Case report

A 25-year patient, Pooja Shinde para three living three, was delivered vaginally at a primary health centre in the early hours of the night. They were then transferred to the nearby rural hospital and then further referred to our tertiary care institute three hours post-delivery after all attempts to remove the placenta had failed.

The patient had already been administered injection methergine, injection carboprost and tablet misoprostol in an attempt to deliver the placenta. When the patient was brought to our institute, she was vitally stable with a pulse of 94 per minute and blood pressure of 110/70. Her uterus was retracted, and there was no evidence of active bleeding on per vaginal examination; the os admitted one finger, and the placenta was confirmed to be in the uterus with its margins not separated from the uterine walls. The patient was given injection carbetocin, an injection pause and the broad-spectrum antibiotic cover was initiated.

The patient gave a history of delayed expulsion of the placenta after delivery in her previous pregnancy. No other significant risk factor for morbidly adherent placenta was found in the patient. No attempt to manually remove the placenta was made for fear of traumatic rupture and dangerous haemorrhage.

Ultrasonography was performed, which subsequently suggested placenta increta with the placenta attached over a 5 cm endometrium surface. The patient was sent for an MRI to delineate further the findings in which myometrial invasion of the placenta was appreciated suggestive of placenta accreta.

Given the patient’s socioeconomic situation, her family’s concern for delayed haemorrhage with methotrexate therapy and no access to a tertiary care centre from their remote residence and possibility of haemorrhage and sepsis and her family is complete, an informed decision for obstetric hysterectomy was

Copyright © 2022 by the Bulgarian Association of Young Surgeons
DOI: 10.5455/IJMRCR.Liturgical-not-surgical-removalofplacenta
First Received: January 18, 2022
Accepted: January 29, 2022
Associate Editor: Ivan Inkov (BG);
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However, since the patient belonged to an extremely impoverished background and was vitally stable and afebrile, the surgery was postponed by a day until the necessary financial arrangements could be made by the relatives and the necessary consents could be taken in place.

However, a few hours before the scheduled surgery, the patient started complaining of the painless passage of clots and on examination, the placenta was felt in the vagina after voluntary separation. Consequently, the patient delivered a bilobed placenta spontaneously. Haemostasis was present, and there was no active bleeding post expulsion.

The patient was spared from the repercussions of major surgery and her family from its ensuing economic burden. Reinforcing the belief that there is a higher force at play and that mystical force begins whenever our strength runs out.

Discussion

Retained placenta is an exacting obstetrical problem accounting for 2.8% of all deliveries.[1] The retained placenta is a significant cause of maternal mortality and morbidity throughout the developing world. It complicates 2% of all deliveries and has a case mortality rate of nearly 10% in rural areas.[2] Expulsion is rapid after vaginal delivery. 90% of placentas deliver spontaneously within 15 min (9 min in active management and only 2.2% remain undelivered at 30 min).[3] Placentas that fail to spontaneously separate can cause significant surgical and hemorrhagic morbidity. Untreated, the retained placenta is considered the second leading cause of postpartum haemorrhage (PPH).[4,5] According to ICD 10 criteria, the placenta is considered to be retained if

1. Excessive bleeding occurring within 30 minutes of delivery without placental separation

2. Placenta not separated 30 minutes after delivery

3. Confirmation of retained placenta tissue >2 hrs postpartum.[6]

Retained placenta can occur in the setting of significant uterine
atony, abnormally adherent placenta, as with placenta accreta spectrum (PAS), or closure of the cervix prior to placental expulsion. [7] Women with prior retained placenta at vaginal delivery had a significantly increased risk of recurrence at a subsequent vaginal delivery.[8]

In the unusual event that manual extraction does not deliver the entire or partial placenta, morbidly adherent placenta (MAP) must be considered an aetiology. The placenta accreta spectrum PAS, which includes accreta, increta, or percreta, can be causes of significant surgical and hemorrhagic morbidity on the labour and delivery floor. While placenta accreta spectrum PAS is relatively rare, particularly in the absence of a placenta previa, it can occur at vaginal delivery when there is no previa. Given the excess morbidity, providers should consider this pathology when a placenta is retained in the setting of significant placenta accreta spectrum PAS risk factors. These include prior uterine surgeries, including hysteroscopic resections, IVF conception, a history of intrauterine adhesions, or a prior history of morbidly adherent placenta MAP or pathologic findings of accreta.[9,10,11]

When a separation plane cannot be created, or extraction attempts begin to invert the uterus, MAP should be suspected. In this case, further attempts to extract the placenta should cease, as the forcible removal of a MAP can lead to a massive haemorrhage. At this point, consideration should be made for hysterectomy, which will be necessary if the patient has an undeliverable placenta with a significant haemorrhage. Alternative treatment has been described, including expectant management or uterine conservation. Expectant management has been described in small studies and refers to the placenta left in situ after diagnosis of PAS. Such management requires careful patient selection and counselling, which risks delayed haemorrhage or infection. Nevertheless, successful conservative management has been described, with placental expulsion, resorption, or removal at a median of 3 months and up to 1 year postpartum.[12,13,14,15]

Extremely few cases of spontaneous expulsion of the placenta in cases of diagnosed placenta accreta and increta have been reported, and none have been documented thus far. In our case, the placenta was delivered spontaneously within 48 hours of delivery without any external aid.

Conclusion
In a case of retained placenta, with the due risk of infection, in the absence of per vaginal hemorrhage, spontaneous separation of placenta could be awaited in low risk cases.

Funding
This work did not receive any grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest
There are no conflicts of interest to declare by any of the authors of this study.

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