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A very rare case report of Placenta Spuria – Incidental finding

[1]Bonam Sri Harika, Assistant Professor, Dept. of OBGY, Apollo Institute of Medical Sciences and Research Institute, Hyderabad.

[2]Krishna Kumari Meka, Professor, Dept. of OBGY, Apollo Institute of Medical Sciences and Research Institute, Hyderabad.

[3]Nisha Bhatia, Associate Professor, Dept. of OBGY, Apollo Institute of Medical Sciences and Research Institute, Hyderabad.

[4]Vennela, Associate Professor, Dept. of Pathology, Apollo Institute of Medical Sciences and Research Institute, Hyderabad.

Corresponding Author: Bonam Sri Harika, Assistant Professor, Dept. of OBGY, Apollo Institute of Medical Sciences and Research Institute, Hyderabad.

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Abstract

Introduction: Incidence of succenturiate placenta is 3-5% in literature. Succenturiate placenta is an anomaly of placenta, where an accessory lobe develops at a distance from the main lobe with vascular connections through the intervening membranes. It is a variant of bilobed placenta. Here we report a very rare case of placenta spuria which is a variant of succenturiate placenta, where there is an accessory lobe with no vascular connections. There are very few cases reported in literature.

Case report: A 19 yrs old primi presented to our OPD at 35wks gestation with fetal growth restriction and preterm premature rupture of membranes. She was managed con servatively with antibiotics and fetal monitoring till steroid cover, after which labour was induced and she delivered a 1.8kg baby vaginally. On examination, placenta was found to have a large accessory lobe attached to the relatively smaller main lobe, with no vascular connections in the intervening membranes. This rare placental anomaly might probably be the cause for fetal growth restriction. Baby was admitted in NICU and was discharged home in stable condition after 10days

Discussion: With the advances in ultrasound, antenatal diagnosis of placental anomaly will help obstetrician in monitoring the pregnancy and plan delivery accordingly, thus decreasing the morbidity

Keywords: Placental anomalies, Succenturiate placenta, placenta spuria, Vasa previa, velamentous insertion

Introduction

The succenturiate placenta is a rare morphological anomaly of placenta where there is one or, more small accessory placental lobes, at a distance from the periphery of the main placenta usually having vascular connections of fetal origin which runs through the connecting membranes[1]. The incidence is reported to be 5%–6%[2,3] by Callen and Benirschke. Placenta spuria is a variant of succenturiate placenta, where the accessory lobe has no vascular connections[4,5,6].

The etio patho genesis is still unknown. The tropho tropism theory, launched by kouyoumdijian in 1980 still holds good. It states that the relative myometrial per fusion determines the focal placental development and atrophy[4,7]. Another theory states that the accessory lobe is developed from the activated villi on the chorionic leave[1]. Risk factors like advanced maternal age, in vitro fertilization, primiparity and implantation over leio myomas or in areas of previous surgery have been cited in the literature[2,6].

This type of placental abnormality can be associated with first-trimester bleeding, fetal growth restriction, poly hydramnios, prematurity, acute fetal distress, abrup tion, antepartum hemorrhage due to vasa previa and retained placenta[1,4,7].

Prenatal diagnosis is the key element guiding towards increased fetal monitoring, deciding time and mode of delivery and thus fetal prognosis[7,8]. But, the diagnosis most often occurs at birth, and only very few cases of prenatal diagnosis with ultrasound are reported[2]. The real-time color Doppler transvaginal ultrasound exam in ation will aid in diagnosis[7]. Careful attention to the cord insertion is required to diagnose the connecting vessels, especially vasa previa[6,8].

Case report

A 19yrs old primigravida, illiterate, homemaker had her booking visit with us after confirmation of pregnancy with urine pregnancy test done at 7wks. She conceived Sponta neously after 6 months of marriage, was a non smoker and nonalcoholic. There was no history of chronic illness in the past

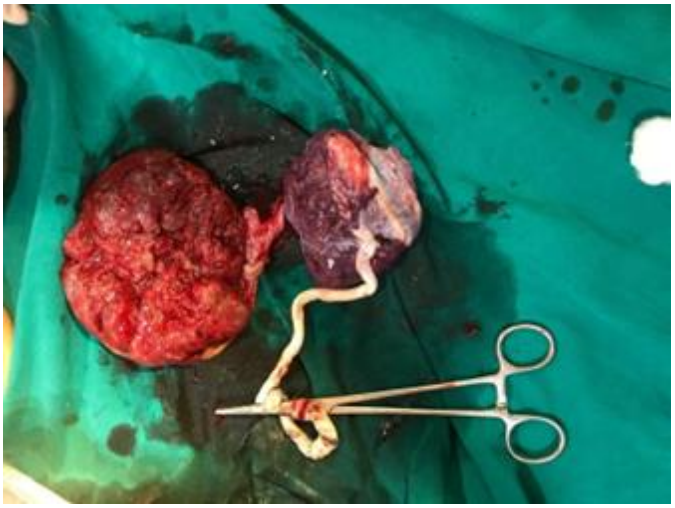
Her booking Body mass index was 17. Early pregnancy scan showed an intrauterine pregnancy corresponding to the Last menstrual period. Her first trimester was un eventful. There was no history of excess vomiting/ unexplained bleeding per vaginum. A nuchal thickness scan was done at 11wks, showed low risk for trisomies. Booking investigations were within normal limits. She had her further visits at 16 and 20wks, where her fundal height corresponded to period of gestation. Anomaly scan done at 19wks showed – a single live fetus, 19+2wks, with estimated fetal weight of 304g, placenta post erior and upper segment and no obvious anomalies.

She was lost for follow up after that and had antenatal checkups elsewhere till 35wks. Came back to us at 35wks with history of ?? leaking per vaginum. On exam ination, her vitals were stable, no signs of Chorio amnionitis, per abdomen – fundal height was 30 wks., symphysiofundal height - 29cm, clinically small for gestational age uterus, relaxed uterus, no uterine tender ness, cephalic presentation & fhs was good. p/s – os was long and closed, no obvious leak / foul smelling discharge demonstrable, curdy white discharge present, high vaginal swab was taken for culture and sensitivity. She was admitted and growth scan showed – a single live fetus, cor responding to 30wks, < 10th centile (fetal growth restriction) with less liquor, Doppler showing

increased resistance in umbilical artery, normal flow in middle cerebral artery, estimated fetal weight of 1.9kg, placenta posterior and upper segment. Non stress test done, was reactive.

She was started on broad spectrum intravenous anti biotics, clindamycin pessaries. Hemogram and complete urine examination were within normal limits, urine culture and sensitivity and high vaginal swab showed no bacterial growth. Inj beta metha sone 12mg two doses were given intra muscularly 24hrs apart for fetal lung maturity. During con servative management, she found to have obvious draining per vaginum and hence a detailed counseling was done about the need of delivery and need of neonatal intensive care for the baby.

After 48hrs of admission, induction of labour done with misoprostol, monitoring was continued for signs of Chorio amnionitis and regular cardio to cograph's. She progressed well and delivered spontaneously a male baby of 1.8kg, with APGAR 6/7/9. Placenta was deliver red by controlled cord traction and counter traction, during which a feeling of giveaway was felt. On careful delivery and examination, two lobes were identified with a thin cord attached to the main lobe which is relatively smaller and at a distance from this is the bigger accessory lobe with no vessels traversing through the inter vening membrane (fig 1 & 2). Placenta was sent for histo pathology and check scan was done to rule out retained products. Baby was examined for anomalies and shifted to nicu and was discharged in stable condition after 10days. Her post-partum period was uneventful. On follow ups, baby was also found to have no further complications in the neonatal period.



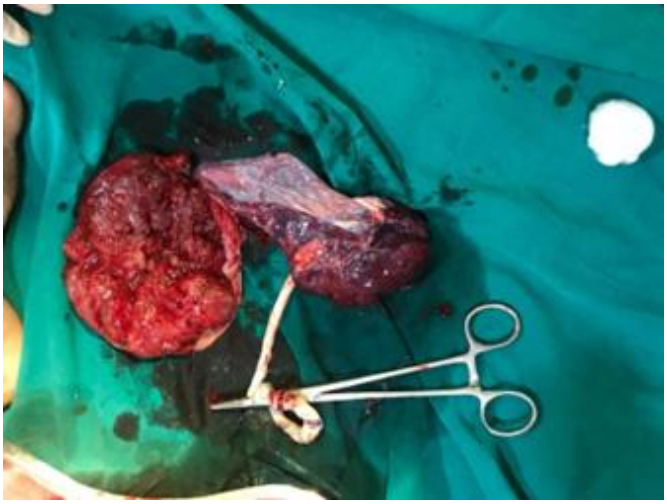


Figure 1 and 2: accessory lobe seen at a distance from the main placenta without any connecting vessels in the inter vening membranes

Review with pathologist

Inspection of the postpartum placenta, membranes, and cord showed -two placental discs 7.5 x 5.5 x 1 cm sized main disc with cord inserted in the center and 12.5 x 8 x 3 cm sized side disc with no cord. The cord had 2 arteries with one vein (3 vessel cord) and the intervening membranes had no blood vessels. The umbilical cord was very thin, measured 22.5 cm in length, no obvious knots noted. Pathologist reported it as placenta spuria.

Discussion

A prenatal diagnosis will permit the clinician to be vigilant and plan delivery accordingly[2]. The use of

ultrasonographic scan findings may be mistaken for an amniotic band/uterine septum[2].Before the introduction of the use of color Doppler, the grayscale imaging was the only mode for diagnosing the placental anomalies[2]. But now, Color Doppler imaging revealing fetal blood flow is helpful in excluding the suspicion of amniotic band and in detection of vasa previa if it coexists[2]. In our case the placental anomaly, remained undiagnosed in spite of periodic antenatal ultrasound examinations, which is not uncommon[1].

Hence, a thorough examination of the cotyledons and membranes of placenta after delivery is of utmost im portance[1]

Complications such as fetal growth restriction, placental abruption, preterm labour, retained placenta, postpartum infection and hemorrhage can occur.[1,8] But, there is no increased risk of foetal anomalies[8]. In case of spuria, weekly antenatal checkups and serial growth scans are to be done and allowed to set into labour spontaneously, with careful attention during the third stage of labour[7].

Conclusion

It is not easy to diagnose these placental anomalies by ultrasound, especially the posteriorly located ones with interfering fetal shadows or associated uterine septum. Having a high index of suspicion regarding the placental anomalies, and a thorough evaluation with the use of colour Doppler with B-flow would help in making the diagnosis. Once identified, the obstetrician can counsel and plan the mode and gestation of delivery.

Though, the case which we reported is a case of placenta spuria, a variant of succenturiate, the risk of antepartum hemorrhage is less likely, as there is no vasa previa. Still, there is the potential risk of having antepartum complications such as first trimester bleeding and fetal growth restriction and postpartum complications such as retained placenta, subinvolution, infection, sepsis, post-partum hemorrhage (especially secondary), need of manual evacuation, and thus morbidity. Fortunately, this lady didn't have any intrapartum or postpartum com plications. To conclude, given the fact that prenatal diagnosis of the placental anomalies and of the umbilical cord decreases the incidence of emergency cesarean section, fetal and maternal morbidity with over 50%.

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