CEOG Clinical and Experimental Obstetrics & Gynecology

Succenturiate placenta - abruption in a young primigravida: an unusual presentation

S. Hamadeh, B. Addas, N. Hamadeh, J. Rahman

Obstetrics & Gynaecology Department, King Fahd Hospital of the University, Alkhobar (Kingdom of Saudi Arabia)

Summary

Succenturiate placenta is a rare placental abnormality, with an incidence ranging between 5-6%. Placenta abruption occurs approximately in 0.5% to 1% of all pregnancies. It has never been reported to occur in association with succenturiate placenta. To the present authors' knowledge, this the first case reported in the literature. It was discovered at post-cesarean section performed for fetal distress in a young primigravida who presented at 37 weeks in active labor. This case report gives an important value to clinical examination and widens the differential diagnosis for pregnant women with unexplained pelvic pain

Key words: Succenturiate placenta; Placenta abruption; Pelvic pain.

Introduction

The incidence of succenturiate placenta is 5-6% [1,2], found usually in the elderly or multiparous pregnants, and those women who underwent in vitro fertilization (IVF). Succenturiate placenta has never been reported in the literature to the best of the present authors' knowledge to occur with abruption. It usually presents with postpartum haemorrhage due to retained placental tissue [3]. The authors describe this case because of the rare incidence of succenturiate placenta in young gravid patients, and seeming to be the first case reported in the literature with abruption.

Case Report

A 20-year-old primigravida, 37 weeks pregnant, presented to the emergency room for the second time in three hours, complaining of severe labor-like pain with no history of leaking or vaginal bleeding. At the initial visit she was evaluated as early labor and discharged. She had uneventful antenatal care in the primary heathcare centre, and had no medical illnesses such as hypertension, or autoimmune thyroid disease. She gave no history of previous uterine surgery, smoking, alcohol consumption, or history of trauma. She gave a history of sexual intercourse few hours prior to her presentation. On examination she appeared to be severely distressed, but her vital signs were stable. Abdominal examination revealed a soft, lax abdomen with no tenderness, fundal height of 36 cm, longitudinal lie, cephalic presentation, not engaged. Fetal heart sounds were 142 beats/minute. The cervix was found to be partially effaced and closed with marked cervical excitation on vaginal examination. She was admitted to the labor and delivery suite for IV hydration and analgesia. Cardiotocograph monitoring demonstrated four to five contractions in ten minutes and fetal heart rate tracing was normal. Obstetric ultrasound revealed a single viable foetus, cross ponding to 36 weeks + 3 days, normal amniotic fluid index, and placenta was left postero-lateral with normal texture. After a further hour, the fetal heart showed recurrent variable decelerations, despite administrating oxygen to the patient and turning her on her side. The patient was advised to undergo a cesarean section and consent was taken. A lower segment cesarean section was smoothly performed. The amniotic fluid was blood stained. A live, male baby was delivered, 3,000 grams in weight, with Apgar scores of 7 and 9 at one and five minutes. After the placenta was extracted, an accessory lobe was noticed in the lower uterine segment, posteriorly. It was removed completely. The lower segment was cleaned and the uterus was closed in two layers. Complete haemostasis was achieved. Total blood loss averaged approximately 600 ml. The placenta was examined postoperatively which demonstrated the presence of succenturiate placenta with 30% abruption (Figure 1). The patient had an uneventful recovery postoperatively and was discharged on third day of surgery in satisfactory condition along with her baby. She was seen six weeks later in outpatient clinic, with no compliants and the abdominal incision had healed well. No further follow up visit was necessary and the patient was discharged from clinic. Informed consent was obtained from all individual participants included in this study.

Discussion

The incidence of succenturiate placenta is 5-6 %[1], common in elderly, gravid multiparas above 35 years, and some who have undergone IVF. This is may be a reflection of increased parity than maternal age [4]. It usually presents with postpartum haemorrhage, secondary to rupture of the accessory lobe or retained placental membranes and rarely causes uterine sepsis or subinvolution [5]. It carries an in-

Revised manuscript accepted for publication October 17, 2017

Clin. Exp. Obstet. Gynecol. - ISSN: 0390-6663
XLV, n. 5, 2018
doi: 10.12891/ceog4431.2018

7847050 Canada Inc.
www.irog.net

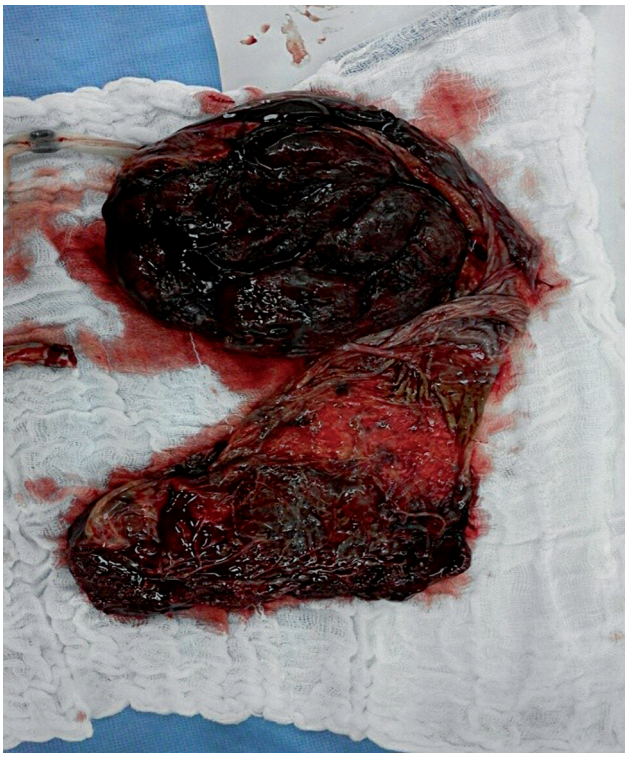

Figure 1. — The placenta examined postoperatively demonstrates the presence of succenturiate placenta with 30% abruption.

creased incidence of vasa previa. Approximately 50% of vasa previa and succenturiate placenta have been reported in the literature [5]. To date there have been no reports of succenturiate placenta associated with placental abruption. The occurrence of succenturiate placenta in the present patient was unusual for her age and parity. There was no clear explanation for the symptoms of severe abdominal pain, acute tenderness on vaginal examination, and cervical excitation. Clinical examination, cardiotocography, and routine obstetrics ultrasound did not aid differential diagnosis. She was hydrated, given analgesia, and kept under observation with continuous monitoring. The use of color Doppler and transvaginal ultrasound can increase the accuracy of diagnosis and improve differential diagnosis [6-9]. It was not performed as suspicion of this condition was overruled due to its rare incidence and possibility of abruption. The final diagnosis was established under direct vision after delivery of the baby during cesarean section. The occurrence of succenturiate placenta associated with abruption is the first case report in the literature and highlights that this combination should be considered as one of the differential diagnoses in any patient presenting with antepartum haemorrhage or unexplained deep pelvic pain in the third trimester of pregnancy with or without fetal distress.

Conclusion

Although succenturiate placenta is known to be seen in elderly or multigravidas, it may still occur in young primigravida. Abnormally located placenta in the lower uterine segment associated with abruption should be suspected in patients with unexplained deep pelvic pain, with or without fetal distress, regardless of the classical clinical signs of abruption. Such patients require colour Doppler and transvaginal ultrasonography to accurately diagnose succenturiate placenta with abruption.

Acknowledgment

This paper was presented as a poster at the Royal College of Obstetricians & Gynaecologists (RCOG) World Congress in Cape Town (South Africa) from March 20-22, 2017.

References

[1] Cunningham F.G., Leveno K.J., Bloom S.L., Hauth J.C., Glipstrap L, Wenstrom K.D., (eds): "Placental abnormalities". *In: Wiliams Obstetrics.* 22nd ed. New York: McGraw Hill, 2005, 620.
[2] Tikkanen M.: "Placental abruption: epidemiology, risk factors & consequences". *Acta Obstet. Gynecol. Scand.*, 2011, *90*, 140.
[3] Nelson LH, Fishburne JI, Stearns BR. Ultrasonographic description of succenturiate placenta". Obstet. Gynecol., 1977, *49*, 79.
[4] Suzuki S., Igarashi M.: "Clinical significance of pregnancies with succenturiate lobe of placenta". *Arch. Gynecol. Obstet.*, 2008, *277*, 299.
[5] Kumari S., Biswas A.K., Giri G.: "Succentrutriate placenta: An incidental finsing". *J Case Rep. Images Gynecol. Obstet.*, 2015, *1*, 1.
[6] Cavaliere A.F., Rosati P., Ciliberti P., Buongiorno S., Guariglia L., Scambia G., Tintoni M.: "Succenturiate lobe of placenta with vessel anomaly: a case report of prenatal diagnosis and literature review". *Clin. Imaging*, 2014, *38*, 747.
[7] Meizner I., Mashiach R., Shavlev Y., Ben-Rafael Z.: "Blood flow velocimetry in the diagnosis of succenturiate placenta". *J. Clin. Ultrasound*, 1998, *26*, 55.
[8] Chihara H., Otsubo Y., Ohta Y., Araki T.: "Prenatal diagnosis of succenturiate lobe by ultrasonography & color doppler imaging". *Arch. Gynecol. Obstet.*, 2000, *263*, 137.
[9] Seleye-Fubara D., Akani C.L.: "Succenturiate placenta: a rare variant in Rivers state Nigeria (a report of one case)". *Niger. J. Med.*, 2005, *14*, 325.

Corresponding Author:
SAMIR GHAZI HAMADEH, MBBS, SBOG, ABOG
Department of Obstetrics and Gynecology
King Fahd Hospital of the University
Imam Abdulrahman Bin Faisal University
P.O. Box 40243
Alkhobar 31952 (Kingdom of Saudi Arabia)
e-mail: Sameer_hamadeh@hotmail.com