

Conservative management of preterm marginal placental abruption with a supracervical clot: A case report

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Citation

G Shyamala, R Lavanya, A Prashanth, P Manopriva. *Conservative management of preterm marginal placental abruption with a supracervical clot: A case report*. The Internet Journal of Gynecology and Obstetrics. 2007 Volume 9 Number 2.

Abstract

Expectant management of preterm placental abruption with marginal placental requires weighing risks and benefits. It involves careful fetal monitoring with close follow-up of maternal hematologic and coagulation profile. A case of marginal placental separation managed conservatively with satisfactory good is reported.

INTRODUCTION

Placental abruption is one of the few obstetric complications that demands immediate termination of pregnancy irrespective of fetal maturity. Placental separation typically is progressive leading to fetal demise and consumptive coagulopathy.

We report a case of preterm peripheral placental abruption presenting with a clot just above the internal os that could be managed conservatively.

CASE REPORT

A third gravida, aged 23 years, presented at 31 weeks of gestation with painless vaginal bleeding. Her previous two pregnancies had culminated in stillbirths. Examination found a stable patient, with mild pallor and minimal bleeding through the cervical os. The sonographic study at admission showed single live intrauterine pregnancy with an estimated fetal weight of 1200 g. There was a heterogenous mass of 10×10 cm just above the cervical os. The placenta was anterior and upper segment, with the lower edge being just above the mass. There was no clinical as well as laboratory finding suggestive of coagulopathy. The mass was thought to be a clot probably due to marginal premature separation of placenta.

Figure 1

Figure 1: Ultrasound at 31 weeks gestation showing a 10×10 cm clot just above the cervical os under the lower margin of the placenta.



In view of prematurity conservative management with close surveillance was offered. She received two packed cells, antenatal steroid prophylaxis and antimicrobials. Maternal coagulation parameters remained normal through the management period. Fetal growth was documented by serial ultrasonography and fetal wellbeing was monitored by biweekly biophysical profile. The clot above the cervical os did not increase in size. However, on the 19th day after admission, she complained of fresh bleeding associated with painful uterine contractions. Emergency cesarean section was done and a live baby weighing 1560g was delivered with good Apgar score. The clot (200g) was extruded per vaginum. In addition, there was a 50 g of retroplacental clot. Postoperatively, there was no complication. The neonate had

a prolonged NICU stay in view of prematurity and respiratory distress syndrome; however subsequently discharged in good condition.

DISCUSSION

The case reported here presented with painless bleeding and evidence of placental separation. However the placenta was found to be in the upper uterine segment. This entity of painless placental abruption is called peripheral placental separation and may often be mistaken for placenta previa. It is different from classical abruption both in its presentation and outcome. Preterm birth rather than birth asphyxia is the major problem in this type of abruption¹. Extravasations of blood at the placental margin dissects the membranes away from the decidua which deprives amnion and chorion of nutrition that often leads to premature rupture of membranes. The associated decidual necrosis might activate the prostaglandin release².

Expectant management for mild placental abruption has been documented in world literature^{3,4,5,6}. The selected pregnancies require careful fetal monitoring with close follow up of maternal hematologic and coagulation profile³. This gives a scope for antenatal steroid administration in addition to prolongation of pregnancy. In the reported case, there was a big clot just above the cervix. Logically speaking, this itself could have acted either as a nidus for ascending organisms or could have caused mechanical dilatation of cervix by stretching the lower uterine segment, thereby initiating preterm labor. Association between peripheral placental separation and preterm labor is well established, in which decidual necrosis causes release of

prostaglandins to initiate preterm labor⁷. However in this case, the conservative approach helped in prolonging pregnancy by nineteen days during which the fetus could gain approximately 300g; also the risk of extreme prematurity could be minimised.

CONCLUSION

There is a place for the expectant prolongation of pregnancy in the management of preterm placental abruption with marginal placental separation during which the fetus add weights and benefits from corticosteroids for lung maturation.

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