

CASE REPORT

Atypical Presentaion of Abruptio Placentae, A Case Report

Yosra Tahir Jarjees

ABSTRACT:

Abruptio placentae is a severe pregnancy complication that occurs in about 1% of gestations. This pregnancy complication has been found to increase maternal and fetal morbidity and mortality considerably. The purpose of presenting this case report is to show that abruptio placentae can be presented in a different way apart from the classical presentation, and to show the association between Rh-isoimmunization and abruptio placentae. The way to reach the diagnosis and how to manage the case has been also discussed thoroughly.

KEY WORDS: abruptio placentae, accidental hemorrhage, rh-isoimmunization, pregnancy outcome.

INTRODUCTION:

Accidental hemorrhage or abruptio placentae refer to premature separation of a normally implanted placenta after twenty weeks of gestation, but prior to delivery of the infant. It's an obstetric emergency that may result in hypovolemic shock and fetal death. Abruptio complicates 1 in 75 to 225 deliveries (0.4 to 1.3 percent) ^(1,3).

The causes of abruptio placentae are unknown. However many maternal risk factors have been identified ⁽⁴⁾. The association between abruptio placentae and Rh-isoimmunization as a causal factor has not been reported in the literature.

Abruptio placentae could complicate the invasive procedures used in the management of Rh-isoimmunization⁽⁵⁾.

THE CASE:

Mrs. T.A was twenty-eight years old lady. She was admitted to Al-Batool Maternity Teaching Hospital in Mosul in January 2005. She was gravida four, para three. Her chief complaint was ⁽⁶⁾ missed period with frequent fainting attacks for few hours' duration, associated with mild abdominal pain and backache. She gave a history of loss of fetal movement for the last twelve hours, and there was no vaginal bleeding. She had delivered her three children by normal vaginal delivery at term;

however, her last baby had been died 3 days after delivery because of severe neonatal jaundice. She never had Rh-immunoglobulin.

On examination: young lady, looked pale, anxious, pulse 82/minute regular, Bd.P. 85/50mmHg., temperature 37.6 C, bilateral leg edema was present, soft abdomen, soft uterus, no uterine tenderness or rigidity. The fundal height of 34 cm with good amount of liquor, the fetal parts could not be palpated and the fetal heart was negative by sonicaid.

Pelvic examination: there was no vaginal bleeding, no leaking of liquor, the cervix was closed, and the presenting part was not felt.

Investigations revealed that Hb was 6.5 gm / dl, blood group was O Rh negative. The platelet count was 180 / mm³, general urine examination was clear, C.X.R was normal, X-ray of the abdomen showed singleton pregnancy of breech presentation without signs of intrauterine death, E.C.G. was normal. Ultrasound and clotting profile were not available.

On the basis of this presentation and investigations differential diagnoses were made:

1. Concealed abruptio placentae.
2. Hydatidiform mole.
3. Severe Rh isoimmunization with intrauterine death of a hydropic baby.

Medical consultation was made and the clinician gave a provisional diagnosis chronic anemia (in spite of no sign of chronic anemia).

Management was started by putting intravenous line, preparing fresh blood and urinary catheter was put in. After two hours of admission; while waiting for blood preparation, the patient started to bleed profusely per vagina with rapid deterioration of the general condition. At that time, diagnosis of abruptio placentae was settled and was suddenly complicated by D.I.C. as diagnosed by the change of the clear urine to a frank hematuria.

Meanwhile, the patient was given a unit of fresh blood and a unit of fresh frozen plasma and intravenous fluid simultaneously. Mild uterine contractions were started which brought a cervical dilatation. Artificial rupture of membranes was done with difficulty and revealed bloody liquor.

As soon as the patient started to improve and the clots started to appear with the vaginal bleeding, a

Dept of Obstetrics and Gynecology, College of Medicine, University of Mosul, Mosul, Iraq.

decision was made to do an urgent cesarean section, as vaginal delivery was expected to be delayed because the cervix was uninducable. At laparotomy; intraperitoneal bleeding was found and the blood was coming out from the uterine tubes and there was couvelaire uterus. A hydropic male baby was delivered with a big placenta and a big retroplacental clot. During that time the patient had received two units of fresh blood, six units of fresh frozen plasma and ten units of crystalloid. Anemia was corrected later on by another four units of blood.

Few days after the operation; an indirect Coombs' test was done and it was positive. The patient was discharged home on the tenth postoperative day on good health. She was followed up after delivery and got pregnant twice after this pregnancy which were ended by first trimester abortion and intrauterine death at the 24th week respectively. The patient is now on contraception.

COMMENT

Rh-isoimmunized pregnancies contribute to a worldwide perinatal and neonatal morbidity and mortality⁽⁶⁾. We presented in this case a severe form of Rh-isoimmunization, complicated by the maternal syndrome or what so called the mirror syndrome. The "mirror syndrome" is characterized by severe hypertension which could be the predisposing factor for abruptio placentae⁽⁷⁾. In this case the effect of Rh-isoimmunization has extended to affect maternal morbidity and has endangered the mother's life.

The diagnosis of abruptio placentae was done after two hours from admission and the termination of pregnancy was done by cesarean section. Cesarean birth is appropriate when delay in delivery is likely to endanger the mother's life seriously because of life threatening hemorrhage or disseminated intravascular coagulation⁽⁸⁾.

Both Rh-isoimmunization and abruptio placentae in this case were presented in bizarre forms. First of all the isoimmunization presented very early, her third baby had been severely affected leading to early neonatal death because of severe jaundice, her fourth pregnancy was complicated by hydrops and the mirror syndrome before the third trimester. It is unusual for blood group O Rh-negative to have severe isoimmunization especially at this gestational age, because the patient already had major blood group antibodies that kill the fetal RBCs before they can elicit an immune response⁽⁹⁾. Probably the young age of first pregnancy and subsequent pregnancies could increase the immunization risks⁽¹⁰⁾. Secondly, the classical clinical features of placental abruption were absent,

the symptoms were very unspecific and signs could be intermingled or obscured by the already present hydropic fetus. Mild fever present in this case could be reactionary one due to the presence of hemoperitoneum. Absence of tachycardia could be explained by irritation of splanchnic nerve plexus and vagal stimulation by the hemoperitoneum. Absence of uterine tenderness in spite of the presence of retroplacental clot and dead fetus could be explained by the following: either the fetus died from the early beginning before the formation of retroplacental clot, because it was severely anemic, or because of the presence of posterior placenta and so we could not feel the tenderness. Fetal demise could precede the abruption and also it might be the predisposing factor for abruption. This was confirmed by some studies⁽¹¹⁾. Posterior placenta also could explain the presence of backache. Nevertheless, uterine tenderness was never demonstrated in this case. Absence of abdominal or uterine pain or tenderness and vaginal bleeding in a woman presented with nosebleed with the presence of a dead fetus and DIC has been reported in a case of abruptio placentae in Parkland Hospital⁽¹⁾. Retrograde bleeding could be due to the unformed lower uterine segment and tightly closed cervix because of having small gestational age with breech presentation.

The severity of abruption at the beginning could not be determined. It was later determined when the patient started to bleed profusely. The symptom complex in this case was illogic for any type of abruption; the presence of dead baby goes with the severe form⁽¹²⁾, although mild form could kill a hydropic fetus. Presence of hypotension goes with the severe form, but the absence of tachycardia goes with the mild form. Presence of anemia goes with the severe form but the absence of uterine tenderness and external bleeding goes with mild form. The rapid deterioration of the patient with the development of DIC goes with severe form of abruption.

It was concluded that this puzzling case could have a relation between severe Rh-isoimmunization and placental abruption as Rh-isoimmunization is one of the causes of poor placentation. In this case, it could be either a co-incident relationship or a causal relationship.

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