Volume : 3 | Issue : 4 | April 2014 • ISSN No 2277 - 8160

Research Paper | Medical Science

A Rare Case of Retained Placenta in Uterine Sacculation

Dr. Shabina Khan — Flat no-6, Red Building, Faculty Residence (R.M.C.H.) Rohilkhand Medical college & Hospital, Pilibhit bypass Road. BAREILLY, U.P. INDIA Pin 243006

Dr. Akanksha Misra — Rohilkhand Medical college & Hospital, Pilibhit bypass Road. BAREILLY, U.P. INDIA Pin 243006

ABSTRACT

Uterine sacculation is a very rare pregnancy complication having an incidence of about one in 3000 pregnancies. It is more commonly associated with retroverted uterus. Isolated sacculation either congenital or acquired is very rare. Without timely intervention, this can cause miscarriage, intrauterine fetal death, preterm delivery, uterine rupture, adherent retained placenta and postpartum hemorrhage. Retained placenta is a common complication of congenital sacculation. Acquired sacculation occurs secondary to uterine curettage, hysterotomy, caesarian section or following misoprost use. A rare case of uterine sacculation, first diagnosed during laparotomy for failed manual removal of placenta, which was removed by exploratory laparotomy in piecemeal.

KEYWORDS : Uterine sacculation, retained placenta, exploratory laparotomy.

Introduction :- Isolated uterine sacculation (diverticulum) is a very rare complication. Sacculation occurs in about 1 in 3000 pregnancies with retroverted uterus.[4] The condition has been defined as a transitory pouch or sac like structure developing from a portion of the gravid uterus and containing all the layers of the uterus. This can cause spontaneous miscarriage, intrauterine fetal death, uterine rupture, preterm delivery, abnormally adherent retained placenta & postpartum hemorrhage.

Case report:- A 30 year old para-2 with live issue 1 patient was admitted with complain of retained placenta for 4 hours. She had delivered a still born fetus by breech presentation in district hospital. She was referred to our institution with retained placenta. She had previous past history of caesarean delivery 2 year back for transverse lie at district hospital.

Patient's vital were stable on admission. On per abdomen examination uterus was about 28 weeks with no guarding & tenderness. On per speculum examination cord was seen with minimum trickling of blood. On per vaginum examination uterus was deviated to left side.

USG had revealed retained placenta with partial rupture, with intact serosa. Manual removal of placenta was attempted under general anaesthesia and failed, as cervix did not open even after maximum dose of muscle relaxant & deepening plane of anaesthesia. In view of placental invisibility and cornual buldge, decision of exploratory laparotomy made. On laparotomy uterine sacculation was seen in left cornu, supero-medial to ovarian ligament, with bluish red buldge (5×8cm) with dilated & tortuous vessels on its surface(Fig.1).

Placenta was trapped in sacculation & removed in piece meal(Fig.2). Placenta weighed about 450 gms with multiple calcification and infarcts. Uterine exploration revealed extremely thinned out sacculation. After placental removal, square sutures at left cornu taken for hemostasis.

Post operative period was uneventful & she was called for follow up after 6 weeks.

Discussion:- Uterine sacculation is very rare. The sacculation is composed of all three layers of the uterine corpus with an excessively thinned out layer of myometrium that is continuous with the normal myometrium of the corpus. The cause of sacculation may be either trophoblastic destruction of uterine wall as proposed by (Umezaki et al), or due to failure of cervical dilatation due to inadverent use of methergin before removal of placenta. It becomes impossible to remove retained placenta in the sac by usual method of manual removal of placenta & curette, so most of the retained placenta is removed through laparotomy, it is an accordance with (Song J E, et al).

Retained placenta without bleeding tried to be managed conservatively by uterine artery embolization & administration of methotrexate, in accordance with (Choung M. et al) in contrast to (M.S.Kokila). So early diagnosis & awareness of uterine sacculation can help medical professionals to be prepared for emergency situations & to reduce maternal morbidity & mortility.



Fig-1



fig-2

REFERENCES

1. MS Kokilla, H Indira, Akhilesh Dutta Diwedi, L Dwarakinath. Trapped placenta and Conceptus in Uterine Sacculation: Two Rare case reports. JSAFOG, May – August 2013;5(2):89-90. | 2. Song JE, Lee SY, Park SH, Jun HA, Lee KY. A case of trapped placenta in uterine sacculation after normal delivery. Korean J Obs and Gyne 2006; 49(6):1338-1344. | 3. Schmidt AP, Glitz CL, Passos EP, Arbo E, Cunha-Filho JS. Hysteroscopy and three dimensional ultrasonography in uterine diverticulum diagnosis. A case report. Am J Obstet Gynecol 2004 Feb; 190(2):561-562. | 4. Lee SW, Kim MY, Yang JH, Moon MH, Cho JY. Sonographic findings of uterine sacculation during pregnancy. Ultrasound in Obstetrics & Gynecology. | 5. Choung M, Rho JH, Son CU, Na WS, Lee BK, Song YR, Ryu JH, Hwang IT, Kim KH. A case of placenta increta in the uterine sacculation which was treated with conservative methods. Korean J Perinatol 2007;18(3):277-285. |